AIDS

In Search of a Social Solution

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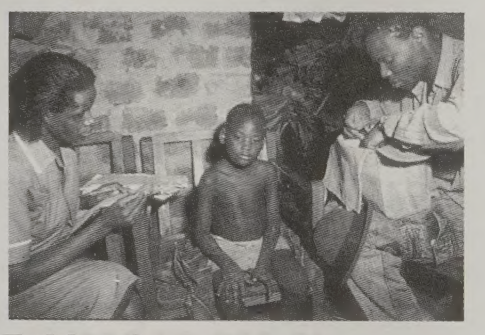
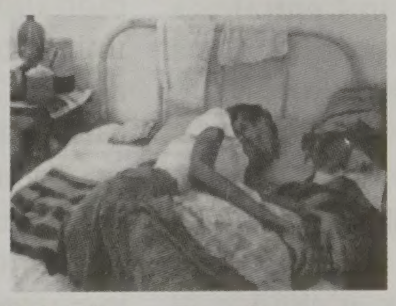
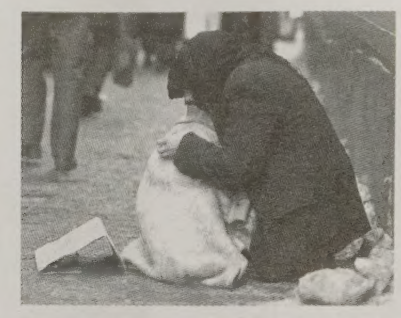
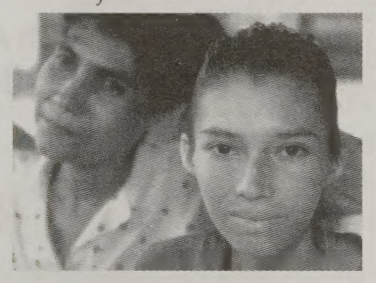
CONTENTS



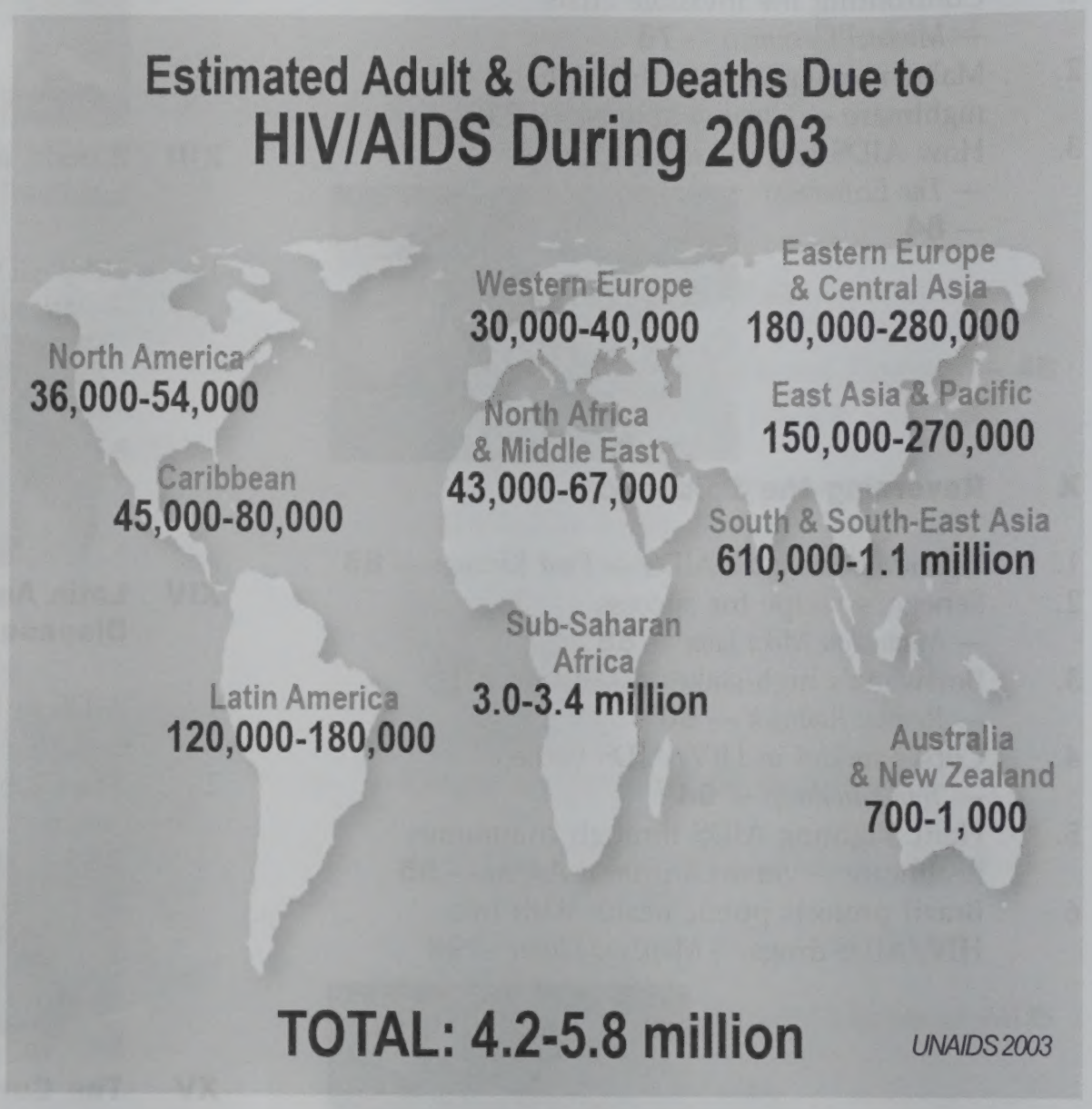






AIDS: A threat to peace and development

Rahab S Hawa



The figures are frightening. The *World Health Report 2004* by the World Health Organisation (WHO) states that 34-46 million people are living with HIV/AIDS. More than 20 million people have died, 3 million in 2003 alone. Four million children have been infected. Of the 5 million people infected in 2003, 700,000 were children, due to pregnancy, childbirth and breastfeeding. The greatest mortality impact is on people between the ages of 20 and 40 years.

Sub-Saharan Africa (SSA) is the hardest hit. In 2003 Africa had two-thirds of the world's people living with HIV/AIDS. UNAIDS estimates that of its total population of 711 million, some 30 million have HIV/AIDS, more than 15 million have died from AIDS and more than 11 million have lost at least one parent to the disease. By 2010, AIDS is projected to leave 20 million African children under 15 years of age without one or both parents. Today one in 12 African adults has HIV/AIDS.

Worsening trends

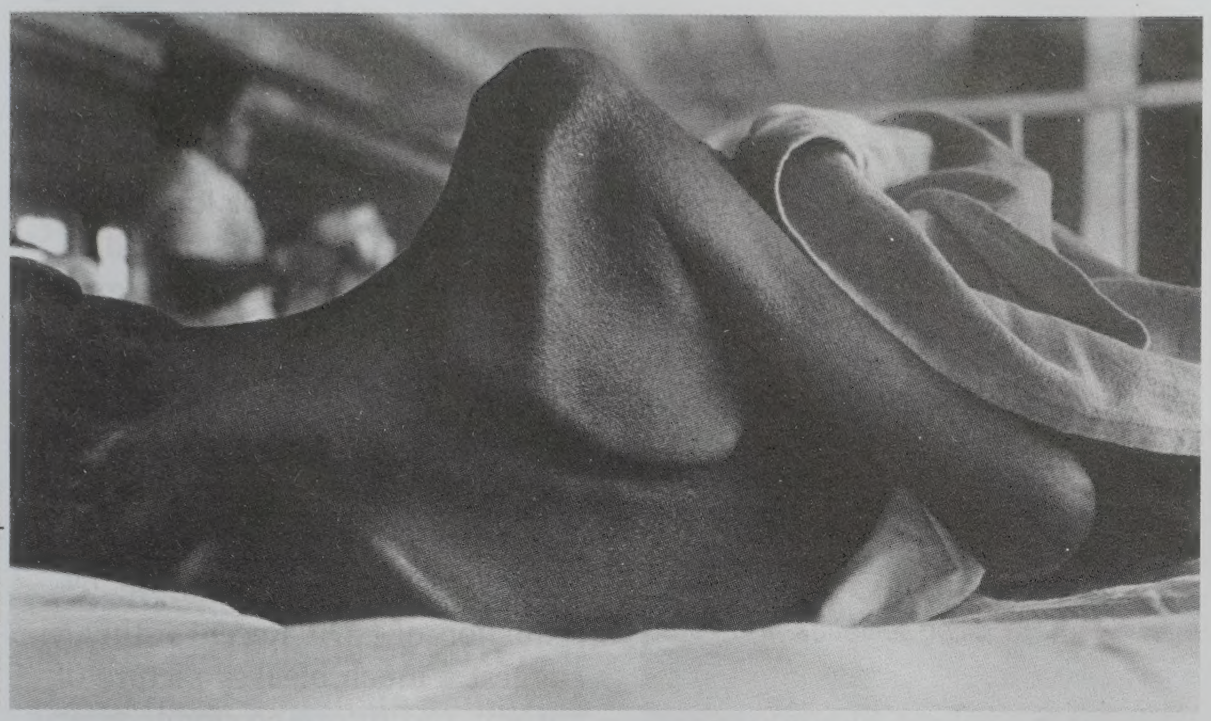
One-fifth of the people infected with HIV live in Asia. In Cambodia, Myanmar, Thailand and six states in India HIV prevalence among adults is more than 1%. In 2003 it was estimated that 840,000 people in China were living with HIV/AIDS. About 70% of these infections are thought to be from injecting drug use or faulty plasma collection procedures. Over 80% of all those infected are men. In India the number of people infected is 3.8–4.6 million and is growing.

Epidemics on the increase in Eastern Europe. In the Russian Federation, where the prevalence is under 1%, 80% of those with HIV/AIDS are under 30 years of age. Injecting drug use is the main cause.

The Caribbean has second highest rates in the world. Prevalence rates are 2-3%. In Latin America some 1.6 million people are infected. In the Caribbean, transmission is associated with commercial sex work. In Central America, rates have been growing and most countries are facing an epidemic.

Rise in child mortality in many countries. There has been a reversal of the declines in child mortality achieved in the 1990s, especially in countries severely affected by HIV/AIDS. In Sub-Saharan Africa 18% of the deaths in under-fives was caused by HIV/AIDS.

Adult mortality has been dramatic. In Eastern and Southern Africa, the chances of a 15-year-old dying before 60 years of age have risen sharply from 10-30% in the mid-1980s to 30-60% in the new millennium. In East Africa mortality among adults with HIV was 20-30 times higher than in the non-infected. The greatest difference in mortality between infected and uninfected people is between the ages of 20 and 40 years. Women die earlier than men – HIV infection rates among women peak 5-10 years earlier than in men. In Thailand, Trinidad and Tobago increases in mortality have been seen. In Thailand the crude mortality rate for those between 15-49 years almost doubled from 2.8 to 5.4 per thousand between 1987 and 1996.



World Health Report

Twenty years after the first case of HIV/AIDS was found, the scourge continues unabated, ravaging societies and entire continents.

The HIV/AIDS pandemic has reduced life expectancy. The gains in life expectancy made in SSA, which was 49.2 years in the late 1980s, is projected to drop to under 46 years in 2000-2005. Overall life expectancy at birth in Africa was 48 years in 2002. It would have been 54 years in the absence of HIV/AIDs. In Botswana life expectancy decreased from 65 years in 1985-1990 to 40 years in 2000-2005. In South Africa it is likely to drop from over 60 years to below 50 years. In Tanzania it is expected to decline from 51 years to 43 years in the last 15 years.

HIV/AIDS with other infectious diseases a public health threat. In SSA, malaria, tuberculosis and bacterial infections are the leading causes of HIV-related deaths. HIV infection increases the incidence and severity of malaria in adults. The pandemic has brought about devastating changes in the epidemiology of TB, especially in Africa where one-third of the population are infected but do not necessarily have the disease (dormant TB). By the end of 2000, 17 million in Africa and 4.5 million people in South-East Asia were infected with both TB and HIV. HIV weakens the immune system and increases the chances of people getting infected with TB. In the US, 16% of TB cases were attributed to HIV/AIDS.

Multidrug-resistant TB and HIV on the increase. This is likely in parts of Asia and Eastern Europe. In India, where some 1.7 million adults in 2000 were co-infected with TB and HIV, there is a multidrug resistance rate of 3% of previously untreated TB patients.

Antiretroviral drug resistance a major new public health problem. Natural viral mutation, and widespread and inappropriate use of drugs to control HIV (halting use, intermittent use, or habitually missed doses) have caused some strains of HIV to evolve resistance to antiretroviral medication. These resistance strains continue to reproduce and destroy immunity in the presence of drugs meant to control the virus and have spread around the world. HIV strains have an amazing ability to recombine to form mosaic viruses. This pace of genetic change forces changes in treatment regimes and increases the pressure to develop new drugs for continued viral control.

The extent of the problem. Virus strains with reduced sensitivity to zidovudine, the first drug used to treat HIV, were first observed in 1989, three years after it was introduced. Resistance to every antiretroviral drug has now been observed. The extent of resistance in countries where antiretrovirals have been used ranges from 5 to 27%. Data from 17 European countries showed that 10% of untreated persons carry drug-resistant virus. Very little data are available from Third World countries.

Resistance in combination therapies. To control resistance, therapies often employ a combination of several drugs. Evidence suggests that the failure of combination therapies to control the disease in patients may exceed 50%. This results in acquired viral resistance to antiretrovirals. Resistance often occurs to more than one or two of the three drugs taken by a patient. This puts people at risk of losing treatment options after treatment has been modified several times, and ultimate death.

Weak healthcare infrastructures lead to poor distribution and inadequate monitoring of antiretroviral usage, which promote drug-resistant strains and reduce the effectiveness of medicines.

Drug toxicity worsens resistance. Studies show that 40% more patients on antiretroviral therapies experience one or more forms of drug toxicity. They include hepatic toxicity, rash diarrhoea, anaemia and peripheral neuropathy. Consequently patients may need to modify their regimen within the first year of treatment. Other adverse effects become noticeable only after prolonged use (one to two years).

The human and social cost

HIV/AIDS epidemics have a disastrous domino effect. Millions of children are orphaned, communities destroyed, health services are overwhelmed, entire countries face hunger and economic ruin. HIV/AIDS is changing the structure of populations – with smaller numbers of working-age adults on whom both children and the elderly depend.

The pandemic is shifting from cities to rural areas. In its earlier stages, HIV/AIDS was mainly an urban problem, affecting more men than women, and those with higher incomes. Now the epidemic has rapidly moved into rural areas, hitting those who are least equipped to deal with it. Today,

95% of people living with and dying of HIV/AIDS are in the Third World. The majority are the rural poor and women figure disproportionately.

The poor are most severely affected. They are most vulnerable to infection and the poorest families hardest hit by suffering, illness and death. This leads to devastating financial hardships and further tragic consequences. Poor families are forced deeper into poverty and households that were wealthy are condemned to a similar fate.

The economic and social costs for households. The impact on population structure and adult life expectancy is enormous. There is loss of income and diversion of income to health expenditure. Families resort to coping strategies with adverse long-term effects which include migration, child labour, sale of assets and spending of savings. Illness or death of one or more members in families means medical costs, funeral expenses and the indirect costs of the impact of illness on productivity.

Threat to agriculture and rural development. The epidemic is undoing decades of economic and social development and causing rural disintegration. In SSA, HIV/AIDS is depleting the food producers and farmers, decimating the agricultural labour force for generations to come. Eighty per cent of the people in the most affected countries depend on agriculture for their subsistence. There are communities where vast numbers of adults are dead leaving only the elderly and children, which affects the transferring of agricultural knowledge.

Loss of human capital. The psychological effects on young people seeing their elders dying in huge numbers at such young ages and developing fears for their own future are immense and have profound effects on economic development. As parents die prematurely they fail to hand on assets and skills to their children.

Africa Recovery

AIDS orphans: children with no future and a potential source of social unrest that threatens to disrupt societies.

HIV/AIDS weakens the process through which human capital – people's experience, skill and knowledge – is accumulated and transmitted across generations.

Crisis of children having lost either or both parents worsens. There are 14 million such children, the vast majority in Africa. The number is projected to double to 25 million by 2010. At that point, 15% to 25% of the children will be orphans. The numbers of orphans will continue to rise as parents already infected continue to die from the disease. The numbers are now so great that many children end up living on the street.

HIV/AIDS exacerbates women's oppression. Women already face severe hardships from inequality, discrimination and victimisation and HIV/AIDS exacerbates the hardships. These very factors explain why women suffer disproportionately from the disease. About 58% of all people living with HIV/AIDS in Africa are women. They are infected at younger ages than men by an average 6-8 years.

Women's unequal status and increased infection. Young women are often forced into unequal sexual relationships and are frequently unable to negotiate safer sex. This will result in unequal losses of life among women creating an imbalance in the adult population. One ominous outcome is that mature men will seek younger and younger women as partners and intensify the risk factors for HIV spread.

The economic impact. The cumulative effects of the epidemic can be catastrophic for long-term economic growth and seriously damage the prospects for poverty reduction. Until recently experts believed that a generalised HIV/AIDS epidemic at 10% adult prevalence reduced economic growth by 0.5% per year. Several country-based studies suggest that HIV/AIDS epidemics result in 1% reduction of GDP. Recent estimates suggest a much bleaker picture of current and future economic effects.

The threat of institutional collapse. The survival and functioning of institutions in a number of African countries are now in danger. Incapacity is critical. There are major shortages of qualified personnel in key organisations. Continuity of staff is low because of deaths and reshuffles. Numerous studies and anecdotal evidence point to the slowing down and near-paralysis of agricultural services, judiciaries, police forces, education systems and health services. The education sector is suffering as the loss of teachers exceeds those being trained. This is a result of AIDS-related illness and death, shifts to the private sector and migration.

The health sector is crippled. Health systems are overburdened especially in poor countries. Systems that cannot cope are weakened further by HIV/AIDS deaths and disability among large numbers of health personnel. In Cote d'Ivoire and Uganda, 50-80% of adult hospital beds are occupied by patients with HIV-related conditions. In Swaziland, the average length of stay in hospital is six days but in 80% of cases increases to 30 days for TB associated with HIV patients.

The severity and complexity of clinical opportunistic conditions are linked to high hospitalisation rates, inpatient mortality and increasing treatment costs.

Rahab S Hawa works for the Third World Network.

The next wave

Advisory group to CIA says AIDS a security threat in strategic countries

In 2002 the CIA declassified a report that projected escalating HIV/AIDS infection rates in China, Ethiopia, India, Nigeria and Russia by 2010. These most populous countries in the world will pose security threats to their regions and the US. The report, labelled as unsubstantiated and exaggerated by experts and NGOs, was given to the governments concerned.

World Health Report

A Chinese boy who became infected through his mother who sold blood to escape poverty in China. The blood sold was through middlemen who often reused needles.

The National Intelligence Council (NIC) says that HIV/AIDS is spreading at an alarming rate in five populous countries of strategic importance to the US—Nigeria, Ethiopia, Russia, India and China. By the end of the decade, these five countries with over 40% of the world's population will have the largest number of HIV/AIDS cases on earth.

According to the declassified portion of an NIC report entitled *The Next Wave of HIV/AIDS* (available at *www.odci.gov/nic*), the number of infected people in the five countries will grow from 14 to 23 million currently to an estimated 50 to 75 million by 2010. This estimate eclipses the projected 30 to 35 million cases in central and southern Africa, the current epicentre of the epidemic.

The NIC is an advisory group to the Director of the CIA with representation from government, academia and the private sector.

These 'next wave' countries are in the early-to-mid stages of the epidemic, says the report. 'The rise of HIV/AIDS will have significant economic, social, political and military implications'.

The epidemic would spark tensions over spending priorities, drive up health care costs and aggravate military manpower shortages. The report states that:

'It will be difficult for any of the five countries to check their epidemics by 2010 without dramatic shifts in priorities. The disease has built up significant momentum, health services are inadequate, and the cost of education and treatment programs will be overwhelming. Government leaders will have trouble maintaining a priority on HIV/AIDS—which has been key to stemming the disease in Uganda, Thailand, and Brazil—because of other pressing issues and the lack of AIDS advocacy groups. '

It notes the following:

- Nigeria and Ethiopia will be the hardest hit, with the social and economic impact similar to that in the hardest hit countries in southern and central Africa – decimating key government and business elites, undermining growth, and discouraging foreign investment. Both countries are key to regional stability, and the rise in HIV/AIDS will strain their governments.
- In Russia, the rise in HIV/AIDS will exacerbate the population decline and severe health problems already plaguing the country, creating even greater difficulty for Russia to rebound economically. These trends may spark tensions over spending priorities and sharpen military manpower shortages.

• HIV/AIDS will drive up social and healthcare costs in India and China. The more HIV/AIDS spreads among young, educated, urban populations, the greater the economic cost of the disease will be for these countries, given the impact on, and the need for, skilled labour.

• The spread of HIV/AIDS in the next-wave countries will be difficult to check by 2010. Treatment of existing infections and prevention of new infections is minimal. Even if effective programmes could be implemented in the coming years, such practical concerns as cost, scale, and experience in health service delivery probably will result in the omission of services to a large number of infected individuals, and the burden of disease will continue to rise.

Weak healthcare

Despite marked differences in capabilities, all five countries have overburdened and underfunded healthcare systems and limited abilities to provide integrated nationwide programmes to test people, track infections and deliver treatment and education programmes.

Disparities also exist within countries in the ability of cities and regions to deal with the epidemic that are likely to grow in the coming years. The healthcare systems of the five countries are summarised as follows:

• Nigeria's public healthcare system, which has been deteriorating for years, is hard pressed to provide even the most basic public services. Many facilities lack electricity, water, and soap; even better-equipped hospitals are beset by strikes by medical staff.

• Ethiopia has never had a viable national healthcare system because of overwhelming poverty and years of war. The government is soliciting international assistance to build its capabilities, but progress on this front is likely to take years.

• Russia's dwindling health services are unable to provide treatment for many victims of heart disease and the skyrocketing number of TB cases. Since the breakup of the Soviet Union, Russia's health infrastructure has deteriorated so much that most experts believe that the population is less healthy now than at any time in the past 50 years.

• India has established nationwide HIV/AIDS centres and a monitoring system, but access to basic medical care is not universal and the free public healthcare system often is highly inefficient. Nonetheless, the government's AIDS organisation was able to reach an estimated 70 percent of households in a recent survey of AIDS-related behaviour.

• In China, a growing number of citizens cannot afford quality healthcare because of privatisation of the public health service. Rural areas, which have the highest HIV infection rates and where 70 percent of the population lives, suffer from major shortages of resources. Funds are being directed towards modernising urban facilities.

Nigeria and Ethiopia

In its assessment of the two hardest hit countries, the report says that the escalating HIV/AIDS crisis could leave Nigeria and Ethiopia seriously weakened states and is likely to reduce their ability to continue to play a regional leadership role.

Rising social tensions over AIDS and related economic problems could exacerbate regional and ethnic tensions within both countries while leaving both governments less able to manage the problem.

The report expects HIV/AIDS in Nigeria will infect as many as 10 to 15 million people by 2010 or roughly 18% to 26% of adults. The infection is most numerous among men aged 20 through 24, but experts caution that infection rates are rising quickly among women. The current official adult prevalence rate is almost 6% but unofficial estimates range as high as 10%, which represents 4 to 6 million people infected.

In Ethiopia, 7 to 10 million will be infected by 2010 because of the high current rate of adult prevalence – between 10 and 18% – widespread poverty, low educational levels and the government's limited capacity to respond more actively. Ethiopia's adult prevalence rate is the highest among the five countries. Official figures cite 2.7 million currently as HIV-positive although experts believe the actual figure may be between 3 and 5 million.

The general poor health of Ethiopians due to drought, malnutrition, limited healthcare and other infectious diseases has caused HIV to progress rapidly to AIDS.

War has significantly contributed to the spread of HIV/AIDS in Ethiopia. Many soldiers contracted the disease during the civil war in the 1980s by having multiple sex partners. When the war ended in 1991, thousands of infected soldiers and prostitutes returned home, spreading HIV/AIDS in their villages and towns.

Russia's future

HIV/AIDS is growing in the Russian military. Currently up to one third of prospective military conscripts are deemed unfit for service because of chronic hepatitis or HIV infection from drug use, says the report.

In Russia, the number of HIV-positive people will rise to 5 to 8 million by 2010. This would reflect an adult prevalence rate of some 6 to 11%, worsening Russia's population decline. Current official statistics list 200,000 people in Russia as HIV-positive. However, the report says experts put the actual number at between 1 and 2 million, which indicates an adult prevalence rate of 1 to 2%.

Intravenous drug use drives the spread of the disease in Russia more than in any other next-wave countries. Drug use is so widespread that many users are integrated into society with jobs and families, suggesting the disease is moving into the general population.

According to the report, India and China are likely to generate the largest number of people infected with AIDS of any country in the world by 2010, but the impact will be lessened because the individuals will remain diffused among large

populations.

However, the more the disease spreads among young, educated, urban professionals, the higher the economic costs will be, given the premium on skilled labour.

Although the two countries can manage the impact of the disease through the end of the decade, the mounting AIDS problem will add to the problems for leaders in both countries in the coming years. For instance:

- Beyond 2010, HIV/AIDS will be an even more significant problem for China and India if government programmes prove ineffective and prevalence rates jump significantly.
- The protests of rural Chinese who became infected through plasma sales suggest that anger with the government's slow response will add to growing frustration in rural areas over rising unemployment, widespread corruption, and poor services.
- HIV/AIDS may become more of a political issue in India as infection rates climb. The debate is likely to focus on who pays for and receives the antiretroviral drugs that Indian firms now are producing.
- As HIV/AIDS moves more into the general population in China, past experience in other countries suggests it will exacerbate an already existing gender imbalance because of the practice of female infanticide. In India and China, because of cultural norms, boys are more likely to be taken care of by their relatives than girls.

India exploding?

In India some 20 to 25 million Indians are likely to be infected by 2010. The report expects India to have the largest number of people with HIV/AIDS in the world within the next few years. But even with the large number, India's adult prevalence rate is only around 1%. The rates vary across the country; in some areas (Mumbai and Pune) the rate is as high as 4%, according to unofficial estimates.

Indian government statistics show 4 million Indians are HIV-positive. The country's high TB rates, however, may be indicative of undiagnosed HIV/AIDS. Some experts believe 5 to 8 million may be infected. Sexually transmitted diseases and reproductive tract infections are rampant in India, increasing the risk that HIV/AIDS infections will be transmitted.

The report states that 'the current trajectory of the disease, limited public awareness, and the lack of resources for a major anti-AIDS program will continue to drive the spread of the disease'.

Chinese dilemma

China is expected to have 10 to 15 million HIV/AIDS cases by 2010. The UN estimates that 1.5 million are currently infected, while experts believe the number is closer to 2 million or even higher.

Several factors are behind China's epidemic – large migrant populations, intravenous drug use, and poor hygiene in plasma sales – increasing the odds that the disease will continue to spread.

About 100 million rural migrants are on the move in China to cities to find work. Sexual contact between migrant men and prostitutes has spread the disease, which advances futher if the migrants return to their villages to visit their families.

HIV/AIDS is rising among intravenous drug users in the south adjacent to Southeast Asia's 'Golden Triangle' of heroin production and distribution routes.

Plasma sales in the rural areas have been a major source of HIV/AIDS spread. Mixing infected blood plasma causes one of the highest known transmission rates for HIV/AIDS and this has infected large numbers of rural, heterosexual villagers who otherwise are at low risk of getting the disease.

The report states that despite growing concern among the leadership, China's sheer size, resource constraints, widespread ignorance of AIDS, cultural taboos about discussing sex, and coordination problems between levels of government will make it difficult to check the spread of HIV/AIDS.

— Rahab S Hawa

Debts and civil wars take their toll

Many countries in which AIDS is a great problem are simply too poor to be able to finance the required countermeasures, or find that taking such measures is impossible due to civil wars. In Burundi, through seven years of internal fighting, the number of infected adults has risen to 7 per cent. The country would have to spend US$43 million per year on combating AIDS – which, in view of its foreign debt totalling US$195 million, is absolutely impossible. In other countries, measures against the spread of HIV/AIDS fail because their governments still refuse to discuss the disease in public. — *Development & Cooperation (D+C)* Vol. 30.2003:2

No political will to fight AIDS

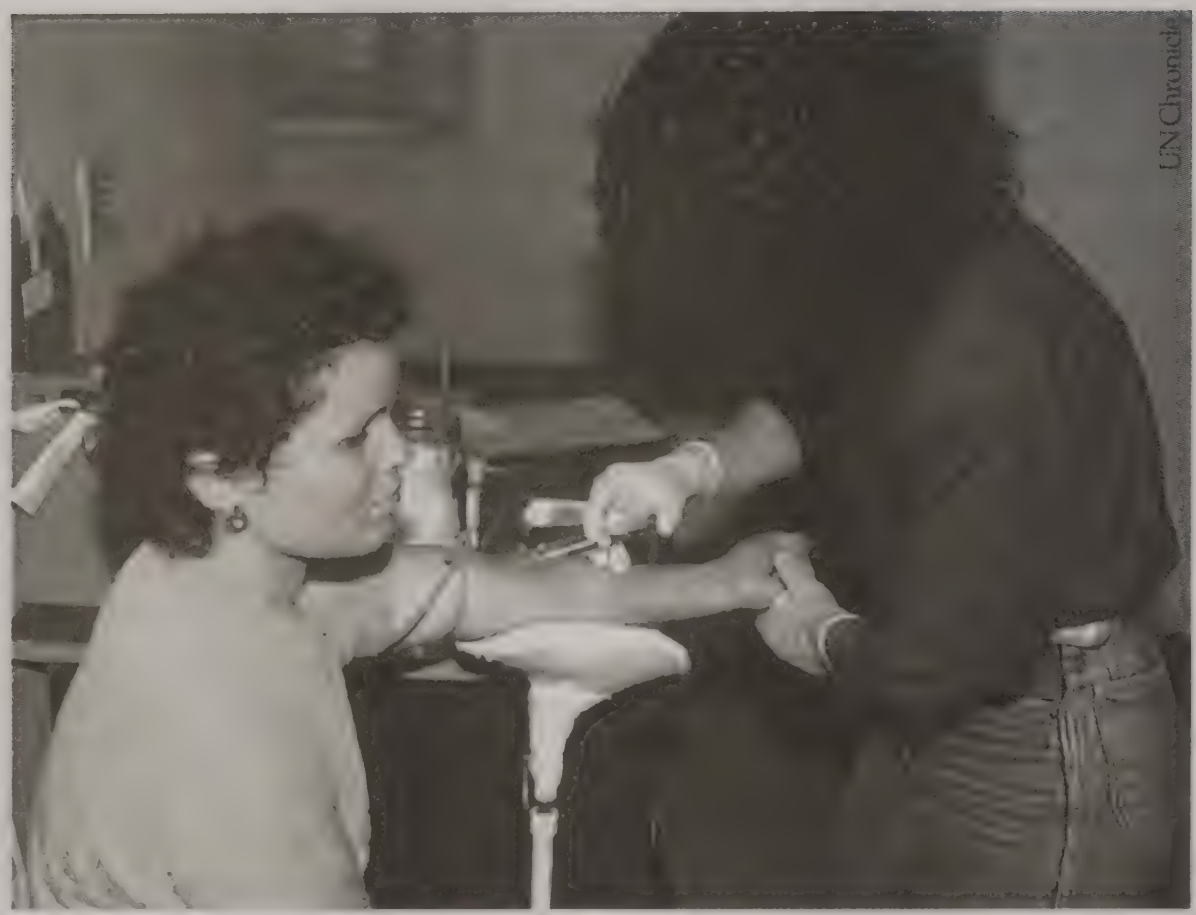
UN Secretary-General Kofi Annan addressed the high-level meeting of the General Assembly on 22 September 2003 with sobering news. In 2001, countries approved the Declaration of Commitment that set concrete goals for containing the spread of HIV/AIDS and aiding its victims. By 2005, 'we should have cut by a quarter the number of young people infected with HIV in the worst-affected nations; we should have halved the rate at which infants contract HIV; and we should have comprehensive care programmes in place', Mr. Annan said. However, he lamented that at the current rate of progress, none of the agreed targets would be met and that 'we are still only half way to the $10 billion a year that is needed by 2005'.

The President of the International Federation of the Red Cross and Red Crescent Societies, Juan Manuel Suarez del Toro, pointed out that the Global Fund initiatives promised to alleviate much of the suffering caused by the pandemic, and it was an ethical duty for Member States to contribute. The $10 billion agreed to under the Declaration of Commitment represented only $250 per infected person over three years, which is less than $1 a day. — *UN Chronicle* No. 4, 2003

Does HIV cause AIDS?

Mae-Wan Ho

The pursuit of truth can take ugly turns. The author traces the controversy surrounding the causes of HIV/AIDS within the scientific community and what happens when dissenting views challenge powerful interests in the scientific establishment.


UN Chronicle

An Anonymous AIDS Testing Centre in Brazil. AIDS dissidents claim that HIV testing is linked to the development of AIDS.

HIV is not the cause of AIDS

Peter Duesberg was, and still is, professor of molecular biology at the University of California at Berkeley, member of the National Academy of Sciences and recipient of a 1985 Outstanding Investigative Grant from the National Institutes of Health. He was tipped as a Nobel candidate for his work on viral oncogenes (genes causing cancer).

But all that came to a crashing end in 1987, when he published a paper claiming that HIV did not cause AIDS, contrary to what the scientific community had come to believe to this day (see box on next page), but was instead the result of drug use. He soon lost all his research grants, but that has not silenced him.

Ironically, Duesberg's hypothesis was generally held before the idea that HIV caused AIDS became accepted (see Box on 'The HIV/AIDS Hypothesis').

Within a few years of Duesberg's paper, HIV-negative AIDS cases began to turn up, and people started to take notice of his theory, which has been refined over the years together with his colleague David Rasnick and others.

In a hefty review published in June 2003, Duesberg and Rasnick, together with Claus Koehnlein from Kiel, Germany presented a long list of questions ('paradoxes') that the HIV/AIDS hypothesis cannot answer, or at least not satisfactorily according to the usual understanding of a viral disease.

One major difficulty that AIDS dissidents have with the HIV/AIDS hypothesis is that the HIV virus is very unusual. It cannot readily be isolated from the AIDS patients. The 'viral load' measured in patients refers, not to actual virus present, but to the amount of viral DNA fragments that can be amplified by PCR from the RNA of a rare virus or of DNA of rare latently infected cells from the patient.

But defenders of the HIV/AIDS hypothesis have no difficulty at all in acknowledging that HIV is a strange new virus that can remain latent for years, being held in check by the body's immune system, which, nevertheless, finally succumbs to the virus.

The most contentious of

The HIV/AIDS Hypothesis

In 1981, a new epidemic began to strike male homosexuals and intravenous drug users in the United States and Europe. The US Centers for Disease Control (CDC) termed the epidemic, AIDS, for acquired immunodeficiency syndrome.

Between 1981 and 1984, leading researchers, including those from CDC, proposed that recreational drug use was the cause of AIDS.

But in 1984, the US government researchers proposed that a virus, now termed human immunodeficiency virus (HIV), is the cause of the epidemic in the US and Europe, and also in Africa.

This hypothesis — HIV causes AIDS — gained instant acceptance within the scientific community.

AIDS As Commonly Defined

AIDS (Acquired Immune Deficiency Syndrome) is the final and most serious stage of Human Immunodeficiency Virus (HIV) disease. HIV causes AIDS. The virus attacks the immune system and leaves the body vulnerable to a variety of life-threatening illnesses and cancers.

HIV is transmitted through sexual contact, through blood (via blood transfusions) or needle sharing (in injecting drugs use), and from mother to child in pregnancy or during nursing.

The Centers for Disease Control has defined AIDS as beginning when a person with HIV infection has a CD4 cell (a type of immune cell) count below 200. It is also defined by numerous opportunistic infections and cancers that occur in the presence of HIV infection.

The symptoms of AIDS are primarily the result of infections that do not normally develop in individuals with healthy immune systems. These are called 'opportunistic infections'.

Common symptoms are fevers, sweats (particularly at night), swollen glands, chills, weakness, and weight loss.

The AIDS-related infections and cancers that people with AIDS acquire as their CD4 count decreases are as follows.

CD4 count below 350/ml: Herpes Simplex Virus causing ulcers in the mouth or genitals; Tuberculosis;oral or vaginal thrush due to yeast infection; Herpes zoster causing ulcers over a discrete patch of skin; non-Hodgkins lymphoma or cancer of the lymph glands.

CD4 count below 200/ml: Pneumocystis carinii pneumonia; Candida esophagitis (painful yeast infection of the esophagus).

CD4 count below 100/ml: Cryptococcal meningitis (infection of the brain by this fungus); AIDS Dementia; Toxoplasmosis encephalitis (infection of the brain by this parasite frequently found in cat faeces); progressive multifocal leukoencephalopathy (a viral disease of the brain caused by the JC virus that results in a quick decline in cognitive and motor functions); wasting syndrome (extreme weight loss and anorexia).

CD4 count below 50/ml: Mycobacterium Avium (a blood infection by a bacterium related to tuberculosis); Cytomegalovirus infection (a viral infection that can affect almost any organ system, especially the eyes).

There is currently no cure for AIDS. However, several treatments are available that can delay the progression of the disease for many years and improve the quality of life of those who have developed symptoms. Antiviral therapy suppresses the replication of the HIV virus in the body. A combination of several antiretroviral agents, termed Highly Active Anti-Retroviral Therapy (HAART), has been highly effective in reducing the number of HIV particles in the blood stream (as measured by a blood test called the viral load). This can help the immune system bounce back for a while and improve T-cell counts.

However, HIV tends to become resistant in patients who do not take their medications every day. Also, certain strains of HIV mutate easily and may become resistant to HAART especially quickly.

Treatment with HAART is not without complications. HAART is a collection of different medications, each with its own side effect profile. Some common side effects are nausea, headache, weakness, malaise, and fat accumulation on your back and abdomen ('buffalo hump', lipodystrophy). When used long-term, these medications may increase the risk of heart attack by affecting fat metabolism.

Medications are also used to prevent opportunistic infections (such as *Pneumocystis carinii pneumonia*) and can keep AIDS patients healthier for longer periods of time.

Source: *Medical Encyclopedia, MedlinePlus.*

Duesberg's claim is that AIDS is not contagious, and not sexually transmitted. That, his infuriated critics say, is simply to encourage people to have unprotected sex, and to use dirty needles for injecting drugs, both of which would expose them to high risks of infection with HIV and a host of other disease agents besides. Yet, that is perhaps the single point on which Duesberg and Rasnick are most adamant. Rasnick has stated categorically, 'I want to stress that AIDS is not contagious, sexually transmitted or caused by HIV or any other virus.' And he is able to cite at least as many papers to support his thesis as his opponents can to refute him.

'HIV does not cause AIDS, it is just a harmless passenger virus,' that's the claim of Duesberg and colleagues. The WHO (World Health Organisation) estimates that 34.3 million are HIV-positive worldwide in 2000, yet only 1.4% developed AIDS. Similarly, in 1985, only 1.2% of the 1 million US citizens with HIV developed AIDS.

Defenders of HIV/AIDS hypothesis will readily admit that the progression from HIV infection to AIDS disease may indeed take years, though it will almost invariably happen.

Like all passenger viruses, it is inherited, i.e., transmitted from mother to offspring, but is not infectious. AIDS disease in infants and children, Duesberg and Rasnick claim, results from prenatal consumption of recreational and anti-HIV drugs by unborn babies through their mothers. That too is a very contentious claim.

Duesberg and colleagues charge that, 'the HIV/AIDS hypothesis has remained entirely unproductive' to this day. There is as yet no anti-HIV/AIDS vaccine, no effective prevention and not a single AIDS patient has ever been cured. Those are 'the hallmarks of a flawed hypothesis'.

A much more productive hypothesis, they say, is that AIDS is a collection of chemical epidemics, caused by recreational drugs, anti-HIV drugs, and malnutrition.

The Durban Declaration

Duesberg is by no means a lone voice. A growing number of 'AIDS dissidents' within the scientific community posed such a threat to the establishment that a remarkable 'Durban Declaration' was made in

Durban, South Africa, as thousands were about to gather for the 13th International AIDS Conference in July 2000. The Declaration began: 'HIV causes AIDS. Curbing the spread of this virus must remain the first step towards eliminating this devastating disease.'

The Declaration, published in *Nature*, was signed by over 5,000, including Nobel prize winners, directors of leading research institutions, scientific academies and medical societies, such as the US National Academy of Sciences, Max Planck Institutes, the Pasteur Institute in Paris, the Royal Society of London, the AIDS society of India and the National Institute of Virology in South Africa.

At the time, President Mbeki of South Africa had assembled a Presidential AIDS Advisory Panel, which included Duesberg and Rasnick among other AIDS dissidents, together with many scientists holding the conventional view. Duesberg and Rasnick were among the 11 co-authors who signed a rebuttal to the Durban Declaration, published in *Nature* correspondence, stating that they 'reject as outrageous' the attempt to outlaw open discussion of alternative viewpoints; it was an act of intolerance 'which has no place in any branch of science'.

The full report of the Presidential AIDS Advisory Panel published a year later makes fascinating reading. It is the best summary of the rather complex debate over all aspects of AIDS, from causation to therapy. Unfortunately, none of the scientific papers cited by the panel members during the debate was included in the report.

AIDS a collection of disparate diseases

The starting point to this controversy is the disparate nature of the diseases that have been lumped together as AIDS. Even a staunch defender of the HIV/AIDS hypothesis, Helene Gayle, then director of the US Centers for Disease Control's National Center of HIV, STD and TB Prevention, and now director of the Bill and Melinda Gates Foundation's HIV, TB and Reproductive Health Program, admitted at the end of the Presidential AIDS Advisory Panel debate, that there is a general lack of standardisation of the definition of AIDS throughout the world. After 15 years of research there is the lack of a 'gold standard' against which to measure the accuracy and reliability of the data generated from the commonly used methods to diagnose HIV infection; and the major task ahead was to develop such a golden standard.

Duesberg and colleagues show that different 'risk groups' for AIDS disease have different conglomerates of 'AIDS-defining' diseases. While Duesberg believes the AIDS disease does exist, Rasnick has argued consistently that AIDS does not exist and that it would 'disappear instantaneously if all HIV testing was outlawed and the use of antiviral drugs terminated'.

For example, Kaposi's sarcoma (a form of cancer) and Pneumocystis pneumonia are highly representative diseases among male homosexuals. But both of those are absent or rare among African AIDS cases. Similarly, tuberculosis is highly represented among Africans but absent or rare among male homosexuals. More tellingly, haemophiliacs who risk infection from blood transfusions have no highly representative diseases at all, only two common infections -- yeast and Pneumocystis pneumonia -- thereby distinguishing them from all other risk groups.

AIDS and recreational drugs

At least 35 published studies have linked illicit recreational use of drugs such as nitrite and other inhalants, amphetamines, cocaine, heroin and steroids, with AIDS, the most recent published in 2002.

Shortly after the AIDS epidemics in the US and Europe began, researchers have indeed found that illicit psychoactive and aphrodisiac drugs consumed at massive doses were the common factors and probable causes of AIDS. Drugs such as cocaine, heroin, nitrite inhalants, amphetamines, steroids and lysergic acid had become widely available and popular in the US and Europe in the 'drug explosion' during and after the Vietnam war, which coincided with the era of 'gay liberation'.

The drug explosion rose steeply from 1980 to a peak between 1990 and 1995, and thereafter declined due to government crackdown. The time course of the drug explosion correlates well with the number of AIDS cases, which rose from zero in 1980 to a sharp peak between 1992 and 1993 before declining sharply. Data from the CDC (Centers for Disease Control) for 1983 showed that all 120 male homosexuals at risk for AIDS and 50 with AIDS were drug users. Consequently, many AIDS researchers favoured the hypothesis that drug-use or 'lifestyle' was the cause of AIDS well into the 1990s.

African epidemic caused by poverty

In contrast, the African epidemic is caused by poverty -- malnutrition and lack of drinkable water -- which is consistent with its random distribution in the population. According to some researchers, it is the same traditional diseases of the poor reclassified as AIDS.

The problems begin with the diagnosis of AIDS, which, in Europe and the United States though not in Africa, is based on detecting anti-HIV antibodies that is poorly standardised and prone to false positives, and also poorly correlated with the presence of the virus or other 'surrogate markers' of AIDS disease, such as the level of CD4+ cells. According to Duesberg, African studies of patients diagnosed clinically as having AIDS showed that 50% were later found to be HIV-negative, that is, free of anti-HIV antibodies.

African AIDS also have a different conglomerate of 'AIDS-defining' diseases compared to other risk groups.

AIDS caused by anti-AIDS drugs

Most if not all HIV-positive individuals with no sign of AIDS

disease would remain healthy, according to Duesberg, especially if they avoid anti-HIV drugs like AZT and newer cocktails.

Since 1987, thousands of US citizens and Europeans with AIDS, and since 1990, even larger numbers of healthy HIV-positive people have been placed on lifetime prescriptions of toxic drugs like azidothymidine (AZT), which terminates DNA synthesis, and protease inhibitors aimed at suppressing assembly of the virus. Since 1996, DNA chain-terminators were mixed with HIV protease inhibitors in drug cocktails.

By 2002, more than 450,000 US citizens were taking drug cocktails to prevent or cure AIDS, and well over half of the 450,000 were clinically healthy at the time they started the anti-HIV drugs. The healthy HIV-positives were treated according to the slogan, 'Time to hit HIV, early and hard', introduced by the *New England Journal of Medicine* in 1995.

Duesberg and colleagues cited at least 63 scientific papers documenting diseases and death of HIV-positive people placed on anti-HIV drugs over and above those in untreated controls. The diseases include AIDS-defining ones like immunodeficiency, leukopenia (low white blood cell count), fever, dementia, weight loss, lymphoma and diarrhoea; plus a host of others that are non-AIDS-defining: anaemia, neutropenia (low neutrophil count), nausea, lipodystrophy (redistribution of body fat), muscle atrophy, mitochondrial dysfunction, hepatitis, birth defects, nephritis (inflammation of the kidney), lactic acidosis, heart infarct.

Similarly, at least 12 papers describe diseases and death in HIV-negative human babies and in HIV-negative animals treated with anti-HIV drugs before and after birth. The HIV-negative babies were born to mothers who have all been treated with AZT, which was found to reduce the natural transmission of HIV by 50% to 70%.

When the HIV infected infants born to mother taking AZT during pregnancy, however, the results showed that the children born to AZT+ mothers were 1.8 times more likely to develop severe disease, 2.4 times more likely to have severe immune suppression, and 3.2 times more likely to die than those born to AZT-mothers.

There is little doubt that the drugs are associated with numerous side effects including those that are 'AIDS defining'. Evidence of toxicities has been accumulating throughout the late 1990s. This finally led the US government to appoint a panel of AIDS researchers to review the situation. In 2001, it issued recommendations to restrict prescriptions of anti-HIV drugs, and that 'treatment for the AIDS virus be delayed as long as possible for people without symptoms because of increased concerns over toxic effects of the therapy'.

Why not test Duesberg's chemical hypothesis?

Although there is extensive circumstantial evidence to support Duesberg's chemical hypothesis, at least for some significant population of patients diagnosed with AIDS, it is difficult to prove without appropriate long-term controlled trials of anti-viral drugs.

If they are right, they claim, 'AIDS would be entirely preventable by banning anti-HIV drugs, by publicising that recreational drugs cause AIDS and by adequate nutrition. Moreover, many AIDS patients could still be saved from fatal damage by drug intoxication, if their AIDS-defining diseases were treated with time-proven, disease-specific medications.'

If they are wrong, then many AIDS sufferers who could benefit from anti-HIV therapy, will be misled. Though this problem can be addressed by much more closely monitored and selective anti-HIV drug administration.

Many researchers who think that HIV does cause AIDS, admit that progression to disease - defined by low CD4+ cell count and high viral load (see Box 'AIDS as commonly defined') - can vary, and can be significantly affected by cofactors including injecting drug use and malnutrition. Others believe that HIV is necessary, though not sufficient, for causing AIDS disease. Vejko Veljkovic, AIDS virologist in Belgrade, Yugoslavia, says, 'AIDS is a syndrome and its different manifestations in different risk groups is not surprising because cofactors which play an important role in the AIDS development are different.' Thus, toxic chemicals and drugs may be among the cofactors that trigger the AIDS disease. Many cofactors induce the production of cytokines, and can suppress the immune system independent of HIV.

So why do current AIDS researchers not investigate, and not even consider the role of chemicals in AIDS or study other non-HIV/AIDS theories to solve the AIDS dilemma?

Duesberg and colleagues blame 'the structure of the large, government-sponsored research programs that dominate academic research since World War II', which favour an establishment that can impose sanctions on dissenters via the 'peer review system'. The most powerful of the sanctions imposed are denial of funding and of publication.

Peer review is devolved to anonymous experts who do not fund applications that challenge their own interests. The review by Duesberg, Koehnlein and Rasnick was blocked twice in the course of more than three years by the peer review process in two separate journals before it finally appeared in print.

Perhaps the biggest hurdle to resolving the controversy is the failure of both sides to acknowledge the full complexity of the immune response. I am entirely persuaded that recreational and toxic anti-HIV drugs as well as malnutrition can all undermine the immune system to produce immune deficiency syndromes. But I would certainly not like to exclude something like HIV that could target the immune cells directly.

Mae-Wan Ho is co-founder and Director of the Institute of Science in Society (ISIS, www.i-sis.org.uk).

Is there an AIDS epidemic in Africa?

An estimated 26.6 million in Sub-Saharan Africa are living with HIV/AIDS, according to official figures. But critics say these statistics are nothing more than hype shrouded in smoke and mirrors. *SAM BURCHER* reports.

Being HIV-positive is the usual requirement for an AIDS diagnosis, but testing for HIV is something of a misnomer in Africa where no HIV test is required to make an AIDS diagnosis. That is because, in October 1985, a conference of public health officials including representatives of the CDC (Centers for Disease Control) and WHO (World Health Organisation) met in Bangui, Central Africa to agree on a diagnostic definition of AIDS in Africa.

This would allow clinicians to identify an AIDS patient and also allow serious counting of such patients to begin. The Bangui definition is: 'prolonged fevers for a month or more, weight loss of over 10% and prolonged diarrhoea'.

Agreeing to this definition has meant that traditional African diseases linked to poverty, war, famine, tropical climate, open latrines and contaminated water are all neatly relabelled AIDS diseases. The consensus on Bangui is that 'it has proved useful in areas where no testing is available.' But as Charles Gilks of the *BMJ* (*British Medical Journal*) pointed out in 1991, 'persistent diarrhoea with weight loss can be associated with ordinary enteric parasites and bacteria.' And, 'in countries where the incidence of TB is high, substantial numbers of people reported as having AIDS may not in fact have AIDS.'

Since 1993, endemic diseases such as TB have been included as AIDS-defining illnesses, and in 2002, the WHO dropped TB down their world's greatest killer list and moved AIDS up as the leading cause of death. The Statistical Assessment Service (STATS) suggested that this is an attempt to 'shift huge chunks of death around'. Cervical cancer has recently been added to the list of AIDS-defining diseases, which is easy to treat if detected quickly, but life threatening if not.

Professor Charles Gershetker, a frequent visitor to Africa as part of his research for the California State University, discovered that some pre-natal clinics were providing tests for HIV and collecting data. The problem with this is that pregnancy is one of the many conditions that can give a false positive result with the standard ELISA test. Other known diseases to trigger an incorrect result are hepatitis, influenza, malaria, TB and recent vaccination.

So the yearly 'HIV-positive' results returned from 4,000 pregnant women are extrapolated by the WHO's epidemiological computer to represent the entire populations' male, female, young and old, burden of AIDS.

Figures for facts

AIDS dissident Professor Jens Jerndal from the Group For The Scientific Reappraisal Of The HIV Causes AIDS Hypothesis suggests that statistics are illusionist tricks to inflate the numbers of AIDS sufferers to inspire sufficient terror or panic in the general population, so as to enable the introduction of mandatory medical interventions, or constraints in freedom of movement or behaviour by those in power. And for that, presenting the cumulative figure of those suffering from AIDS has more impact than reporting the number of new cases in a year, which would give a more accurate picture of the epidemic.

The practice of widening the definitions of diseases diagnosed as AIDS also concerns Prof Jerndal. At least 29 different illnesses that existed before AIDS are considered as AIDS when they are accompanied by an HIV-positive test. But there are more than 60 different conditions that can cause a positive result that bear no relation to HIV or AIDS. Jerndal's message is that the world has been sold the unproven HIV causes AIDS dogma along with a fatal drugs regime of conventional medicine that goes with it.

Misdiagnosis can have a devastating effect on the life of a patient and aside from inaccurate results a positive test for HIV is by no means predictive of the development of AIDS. But, so far no real distinction is made between the two. Worse still, in Africa, an AIDS diagnosis can mean existing treatment is withheld altogether because of the entirely unjustified fatal prognosis attached to the illness.

In whose interests would be the creation of numbers of people suffering from a fatal disease in epic proportions? In the US in 2000, under President Clinton, AIDS in Africa, not in the US, was declared a matter of national security. It was suggested that while AIDS was confined to the homosexual community in the US, it was containable, but once heterosexual transmission had been established in Africa then everyone had a reason to panic and AIDS budgets soared.

All Africans are being unfairly labelled as insatiable, sexually promiscuous, reckless people while their key issue of poverty remains ignored. Statistics report HIV rates of infection as high as 25% in some African countries and more women

Africa Recovery

than men are infected. World Bank statistics for those living with AIDS in sub-Saharan Africa are at 29.4 million while in Cairo, Egypt, a short boat trip down the river reveals 215 cases of HIV/AIDS in a population of 65 million.

Aid not AIDS

UN anti-poverty strategies that promised to halve debts in sub-Saharan Africa by 2015 are now, according to UK Chancellor Gordon Brown, more likely to happen in 2147. Under the auspices of the World Bank and the International Monetary Fund $2.5 billion is transferred from sub-Saharan African banks into foreign banks and creditors' accounts every year. A further blow is President Bush's proposal to cut core funding to Africa. Gordon Brown and singer Bono are calling for a doubling in aid cash to Africa.

People are dying of diseases in Africa caused by inadequate living conditions and they deserve help now to improve the quality of life primarily by access to clean water and good nutrition. Constructive help like sustainable agricultural plans would enable them to feed themselves. And encouraging the use of affordable insecticide-treated mosquito bed nets would combat the millions of annual infant malarial deaths.

Assistance like this could replace the manipulative measures of foisting US tax credit goods on African states. While thousands starved, pharmaceutical companies made incongruous 'donations' of appetite stimulants to Sudan, and silicone implants to Malawi. These companies then claimed tax credit for their useless gifts and the recipient countries had to pay to dispose of them.

It is unlikely that attaching emerging and traditional diseases to an AIDS definition is useful for tackling the key problems of malnutrition and sanitation, but it would encourage the use of pharmaceutical drugs. Costs for conventional drugs are still prohibitive for many Africans and purchasing governments incur even greater debts to the World Bank. In order for any drug therapy to be truly successful it must be used in tandem with adequate nutrition and sanitary conditions.

One of the most recent combination therapy drugs is called Nevirapine; a non-nucleoside reverse transcriptase inhibitor (NNRTI), which reduces the viral load in HIV infection, is causing neuropsychiatric side effects in patients with HIV, but with no history of mental illness. Three patients undergoing treatment developed psychotic reactions to the drugs. Two made impulsive suicide attempts after suffering command hallucinations while the third experienced persecutory delusions and depressive thoughts after starting Nevirapine. Physical side effects include hepatotoxicity, gastrointestinal symptoms, and dermatological reactions.

Dr David Rasnick, a leading AIDS dissident and designer of protease inhibitors (PIs), a drug used in the treatment of HIV infection, is confident that PIs can help reduce viral load, but is unconvinced that HIV causes AIDS. He said in an interview for the *San Francisco Herald* in October 2000, 'In fact, I'm pretty sure right now there's no such thing as an AIDS epidemic in Africa, from my previous two trips last May and this July. The reason I say that in brief is that we've looked and looked and asked people, the government ministers, we asked the director of the medical research council in South Africa, the Centers for Disease Control in the US, everybody we could ask, "What are the numbers of AIDS cases in South Africa and how many AIDS deaths?" No answer at all. Zero. To this date we do not have an answer to that, and in fact, I don't think there is any such thing as AIDS going on in South Africa. It's just the same old things that Africans have been suffering and dying from for generations due to poverty, malnutrition, poor sanitation, bad water, that sort of thing. We're calling it AIDS now, instead of by the old-fashioned names that were more honest. '

Professor P Addy, Head of Clinical Microbiology at the University of Science and Technology in Kumasi, Ghana, backs up the opinions of AIDS dissidents. He said: 'I've known a long time that AIDS is not a crisis in Africa as the world is being made to understand. The West came out with those frightening statistics on AIDS in Africa because it is unaware of certain social and clinical conditions. In most of Africa infectious diseases, particularly parasitic infections, are common. And these are the conditions that can easily compromise or affect one's immune systems.'

He concludes: 'The diagnosis itself, merely being told you have AIDS, is enough to kill and is killing people.'

Sam Burcher is a researcher with the Institute of Science in Society (ISIS).

A paradigm under pressure

Huw Christie

A whole industry, involving big business, political interests, personal ambition and large sums of money, has evolved around AIDS. Its pronouncements go largely unchallenged within the scientific establishment, and those who dare criticise or question orthodoxies are silenced.

Since 1987, opposition to the hypothesis of a new retrovirus causing AIDS has developed along two main axes: Peter Duesberg of the US National Academy of Sciences contends that HIV would be the only human retrovirus to cause illness, and it doesn't; Eleni Eleopulos's Perth Group holds that the putative identification of HIV, perhaps like that of other human retroviruses, is one more misinterpretation of biological markers. Both predict the emergence of long-term survivors of HIV diagnosis - without having received antiretroviral therapy - and, as this was increasingly demonstrated by the facts, their dissenting views, long rejected out of hand, began to gain credence.

Eleopulos, of the Medical Physics Department of the Royal Perth Hospital, Western Australia, was eventually endorsed by the scientific publishing mainstream in 1992 when her team's seminal paper 'Does a positive Western blot prove HIV infection?' appeared in *Bio/Technology* (now *Nature Bio/Technology*). The paper presented abundant evidence that so-called 'HIV antibody tests' have never been validated against conventional detection and isolation of an actual virus (HIV); that the term 'virus isolation' was misleadingly applied in 1984; that a range of stimuli that are not a human immunodeficiency virus can be responsible for what are interpreted as HIV antibodies in test-positive people (including, reported later, 88% of 'AIDS-defining' illnesses themselves, principally the fungal and mycobacterial); and that insofar as there is a unifying factor behind AIDS-defining illnesses in the so-called risk groups, a theory of group/behavioural-specific oxidative stresses explains the mechanisms and predicts effective antioxidative therapy.

If this work were gaining credence, it may explain the publication in 1998 of 'Oxidative Stress' in *Cancer, AIDS and Neurogenerative Diseases*, with one Luc Montagnier as principal editor, which seems to indicate a growing interest in alternatives to the generally accepted view.

Nonetheless, clinical practice in HIV/AIDS is no more amenable to scientific revision than in other areas of medicine. The daily clinical round of HIV/AIDS focuses on immune system CD4/T-cell counting -- HIV is killing your CD4s quickly/slowly - and Viral Load Tests - you have x thousand viruses in each millilitre of your blood and it's rising/falling. Medical and scientific proponents of a re-evaluation of the HIV hypothesis argue that both these measuring procedures for indirect biological markers of presumed pathology depend on oversimplified interpretive applications of rootless technology.

Detecting HIV?

CD4 counting (for the immune system cells known as Cluster Differentiation 4) is dogged by an acknowledged margin of error: any numerical result per millilitre in fact represents a range of approximately plus or minus 120 - although treatment decisions and patients' subjective wellbeing often depend on specific numberial values.

And CD4 monitoring is rendered deeply ambiguous by the persistent failure to find evidence of the untoward destruction of T-cells in patients diagnosed with AIDS (as opposed to the redistribution of cells away from peripheral blood, or their transformation into CD — another cell). Least of all has there been any proof of CD4 destruction by lab cultures of 'HIV', a fact noted by a curious Montagnier among others.

The Viral Load test, a more recent addition to the clinical arsenal, has been lambasted by the inventor of its basic Polymerase Chain Reaction (PCR) technique, Nobel Prize-winning chemist Kary Mullis. He calls the use of his genetic amplification method for counting an 'oxymoron', inappropriate for 'AIDS-medicine'. In addition, say other scientists, there has never been agreement on the genetic structure of HIV which the PCR seeks to amplify: there have been 19 discordant claims to have analysed a complete HIV genome.

This, say anti-HIV scientists, may be an inevitable consequence of the failure to purify or isolate any HIV when it was first 'discovered' or at any time since. In an interview published in 1999, Montagnier stated that he never presented any electron microscope images of purified HIV back in 1984/85, despite great efforts, because at the appropriate experimental density in the test solution his team found no particles with 'morphology typical of retroviruses'. Pressed by the astonished interviewer, Djamel Tahi, Montagnier confirmed: 'I repeat, we did not purify.'

World of Work

The Viral Load test is also problematic. It aims to amplify a fragment of just one HIV gene, yet traditional teaching texts hold that the healthy human genome contains over a hundred dormant quasi-retroviral genetic sequences, expression of which can be stimulated with oxidation.

Without purification/isolation and characterisation of a genome of exogenous, infectious HIV, it is, therefore, a matter of guesswork as to exactly what the genetic fragments being found in people consenting to Viral Load tests derive from. Are they fragments of viral or human code?

Recently published accounts of positive Viral Load results in HIV-antibody negative people, and the clinically accepted margin of error in Viral Load testing — plus or minus 300% - add to growing disquiet over the meaning and application of this reputedly 'smart' technology. Nor does the recent claim, universally and uncritically reported, of the detection of the origins of HIV in chimpanzees offer any answers. The researchers had to cobble together a would-be viral genome: 'Because virus isolation from the autopsy tissues was unsuccessful, we used PCR to amplify four overlapping subgenomic fragments.'

Worse than the disease

The other major area of analysis for the AIDS dissidents is the prescription and use of anti-HIV drugs. The first, AZT, came into use in 1987, having sat on the shelf because of its excessive toxicity since its development as an anti-cancer agent in 1963. The large Anglo-French study of AZT, the Concorde Trial, co-sponsored by the UK Medical Research Council, found a 25% higher mortality in asymptomatic people who took it than in those who didn't.

Current anti-HIV medications, protease (enzyme) inhibitors (Pls), often used in combination still with AZT and its like, were heralded at the pharmaceutical company-sponsored Vancouver AIDS Conference in 1996, but are now acknowledged to be dangerous and of unclear benefit. The UK's All Party Parliamentary Group on HIV/AIDS reported in July 1999: 'Serious side effects and long-term difficulties with this class of drugs are now emerging and have been shown to affect the majority of people taking them.' It encouraged 'regimes that do not contain a PI'.

For want of a true gold standard (purified, isolated HIV), there are currently at least nine differing official criteria worldwide for HIV-antibody positivity, even on the more respected of the HIV-antibody tests, the Western blot. A person can legally test positive in Africa and negative in Australia, or negative in the US Red Cross and positive in the CDC (Centre for Disease Control and Prevention).

Fresh research from New York University Hospital shows that if a person's blood is not diluted 400 times before testing, everybody reacts positive on an HIV-antibody test, demolishing the 15-year-old proposition that HIV antibodies are made only in response to HIV.

The results of the research imply either that HIV tests cannot reliably detect HIV, or that there is a 100% public prevalence of HIV infection, albeit in many people at low levels.

The pre-emptive legal defence by test-kit manufacturers in their product literature — 'At present there is no recognised standard for establishing the presence or absence of HIV antibody in human blood' — is essential, given that imprecision on this scale is a serious liability.

According to Perth Group scientist Dr. Valendar Turner, in a 1998 report commissioned from Medical Productions for the UK's Channel 4 News but never shown: 'If there is such a thing as an AIDS-causing retrovirus, then its unique body parts, that is its proteins, should only be found in HIV-positive individuals and individuals who have AIDS. But this is not the case. All the principle HIV proteins have been found in all manner of cells from healthy human beings who are HIV-negative.'

Despite the fierce controversies that have dogged the history of HIV/AIDS research over the years, a resolution may be in sight. At the 1998 World AIDS Conference in Geneva, the Eleopulos team, and other scientists, including French electron microscope pioneer Professor Etienne de Harven, German virologist Dr. Stefan Lanka and British epidemiologist Professor Gordon Stewart, officially presented for the first time at the conference the data that challenge claims to have isolated and proved the existence of HIV, and to have established the specificity of HIV tests. Publication along these lines increases monthly.

The implications culturally, legally, scientifically and medically of even a partial recognition that AIDS was defined by its own forging of a technocratic cul-de-sac would be extensive and profound, though not, perhaps, altogether unbearable.

Huw Christie is the editor of *Continuum*, the London-based magazine dedicated to providing fuller understanding of HIV/AIDS. This piece was first published in *Index on Censorship*.

Uncommon questions

A feminist exploration of AIDS

While many women's health advocates have argued that women have been excluded from treatment and are discriminated against in programmes that address HIV and AIDS, this critique has generally not extended to challenging the prevailing HIV/AIDS orthodoxy itself. In a recent study, WOMEN'S HEALTH INTERACTION (WHI) raises 'uncommon questions' about the HIV/AIDS dilemma.

Does HIV always lead to AIDS?

The relationship of HIV to AIDS is not an obvious and undisputed fact, but rather a theory constructed, advanced and defended by the scientific and medical community. The dominant medical model of AIDS (Acquired Immune Deficiency Syndrome) states that AIDS is a condition directly linked to HIV, a virus that attacks the body's T cells and immune system, weakening the body's capacity to resist disease, thereby making it susceptible to a long (and rapidly lengthening) list of 'opportunistic' infections.

AIDS is a medical 'construct', and integral to its definition and diagnosis is the presence of HIV. In the US, for example, according to the Centers for Disease Control (CDC)'s definition, a person cannot have AIDS, regardless of other symptoms, unless she has HIV, since HIV is considered the cause of AIDS and is part of its diagnosis. As Celia Farber reports, 'It is the perfect circular definition, and has ensured the AIDS establishment a near-perfect correlation between HIV and AIDS.'

Do socio-economic and political factors play a role in AIDS?

The greatest number of AIDS cases is reportedly among groups which are socially and economically marginalised. It is well known that social, economic and political conditions play integral roles in building, or in destroying, immunity. People living in poor social and economic conditions do not have access to good nutrition, safe water, or adequate health care. Their immune systems may be weakened and they are often much more susceptible to disease.

In Europe and North America, AIDS-defining diseases include over 30 conditions, including tuberculosis and cervical cancer. In addition, an HIV-positive test and a T-cell count below 200 in the absence of other symptoms may be adequate for a confirmed diagnosis. Conversely, despite the official definitions and AIDS orthodoxy, in Africa and other developing countries the presence of HIV is not necessary for an AIDS diagnosis, and testing is rare. The World Health Organisation's clinical-case definition for these countries is based on a list of symptoms that include chronic diarrhoea, prolonged fever, 10% body weight loss in two months and a persistent cough.

These criteria for AIDS are disturbingly similar to endemic diseases such as dysentery, tuberculosis, cholera and malaria. Many experts, such as Dr. Harvey Bialy, eminent Science Editor of *Bio/Technology*, a sister publication of the journal *Science*, argue that AIDS is simply a new name for old diseases that result from inadequate health care, widespread malnutrition, endemic infections and unsanitary water supplies. In this case, it would be very easy for widespread, and counterproductive, misdiagnosis of AIDS.

For those who do undergo testing for HIV, the tests have been proven remarkably unreliable, particularly in developing countries. The potential for false positives is very high partly due to anomalies in the tests themselves, but also because - as is now well-documented - people who live in areas where leprosy, malaria, and TB are prevalent, routinely produce false positive HIV test results since the test reacts to the proteins of the antibodies for these diseases.

A growing number of scientists and researchers argue that, to be effective, AIDS research and prevention has to address structural poverty, unhealthy living conditions and the lack of primary health care, rather than simply attempting to change peoples' sexual behaviour. Shenton reports that in Uganda, 'As a result of the redefined AIDS problem, coping with malaria, a curable disease, has become seriously neglected with cutbacks in funding for malaria control and medication.'

The focus on the HIV virus as the cause of AIDS and the key to its prevention means that research and treatment programmes continue to search solely for pharmaceutical cures. Financial and human resources are diverted away from addressing the underlying social and economic causes of the chronic immune suppression that blights the lives of hundreds of millions who live in grinding poverty.

Has the changing definition of AIDS affected women?

The list of AIDS-defining diseases is being continually changed, and from year to year diseases are added to or deleted from the list. Recently, more attention has been given to women's specific conditions related to AIDS. In the beginning of 1993, the CDC in the United States added cervical cancer and pelvic inflammatory disease (PID) to the list of AIDS-related conditions. Notably, and not surprisingly, at the same time that these diseases were added, the number of women

diagnosed with AIDS and HIV increased rapidly, and often retroactively.

However, many researchers believe that there is in fact no causal link between HIV and cervical cancer, and that the potential for misdiagnosis is very high. In both cervical cancer and PID, researchers claim that the conditions themselves may cause a woman to test positively, but falsely, for HIV antibodies. It is important to note that no other kind of cancer, with the exception of kaposi sarcoma, has been linked to AIDS or to other immune suppression conditions.

Are heterosexual women really at high risk?

In hard numbers, relatively few women are diagnosed with AIDS even with the inclusion in recent years of specific women's diseases such as cervical cancer. As Celia Farber reports, fewer women are becoming infected, and 'the bulk of heterosexual transmission is taking place within a disenfranchised community that is marked by poverty, poor health care, sexually-transmitted diseases and drug use'. This conclusion is not new. Stephen Strauss, a science editor for the *Globe and Mail*, years ago asked the critical question, 'If AIDS is caused solely by HIV, and spread via sexual intercourse, then why is it not spreading along sexual lines so much as along sociological lines, with poverty and drug use being central co-factors? ... prostitutes have no higher incidence of either HIV or AIDS than any non-risk groups - unless they are IV-drug users.' The work of Eric Mintz (1988) also undermined the conclusion that women were at significant risk of contracting HIV through sexual contact.

Should pregnant women be subject to routine or mandatory HIV tests?

While HIV testing of pregnant women is theoretically done only with the consent of the woman, some provinces in Canada have recently made routine HIV testing and counselling the norm. In 1998, the Ontario Ministry of Health announced that the provincial screening programme was being expanded to include voluntary prenatal HIV testing for all pregnant women, regardless of other risk factors. Under the new programme, approximately 150,000 prenatal HIV screening tests will be performed annually.

According to the Health Ministry, the primary goal of the new programme is 'to assist women in accessing appropriate treatment for HIV as early as possible. Anti-retroviral treatment will help to maintain the health of the woman as well as reduce the risk of passing the virus to the baby'. According to the Ontario Government, 'many women with HIV do not have obvious risk factors - most are diagnosed only after their children are found to have the virus'. The test is also being recommended to all women considering becoming pregnant.

Elsewhere in Canada other provinces are making changes. The Quebec Ministry of Health and Social Services has initiated a new programme recommending that all pregnant women, and women contemplating pregnancy, be offered an HIV test. Since 1993, the Northwest Territories' Maternal and Perinatal Committee, which has representation from the Department of Health and Social Services and the Northwest Territories Medical Association, has recommended that all pregnant women be tested for HIV. This is now considered routine, although technically women may 'opt out'.

There are real concerns about routine HIV testing of pregnant women. First, pregnancy is a condition that is known to cause cross-reactions with HIV tests, leading to higher rates of false positive test results. The Alberta Reappraising AIDS Society (ARAS) asserts that testing this low-risk population will likely result in many false positives, with dangerous consequences. They maintain that the health of every pregnant woman who is branded HIV-positive, as well as that of her baby, will be damaged by both toxic AZT therapy (used to fight HIV) and the prohibition against breastfeeding. ARAS suggests that people have forgotten some of the lessons history has taught us about the dangers of certain drugs in pregnancy. For example, they wonder, 'Does anybody remember Thalidomide?'

Does the public have access to alternative information about AIDS?

Those people who have claimed that HIV does not cause AIDS or is not the sole cause of AIDS - and the numbers within the medical community are growing - have been vilified by both the medical establishment and the media. The most famous 'heretics' in the HIV=AIDS theory—experts such as Root-Bemstein, Duesberg, Papadopulos-Eleopulos and the Perth Group, Mullis — all have impeccable credentials. Despite their record of excellence and scientific rigour, these scientists face severe criticism and are ostracised by the scientific establishment. Efforts to silence these and other scientists have been intense. They have lost funding and the respect of their peers and they find it difficult to publish in mainstream scientific and medical journals.

Given the repercussions to outstanding scientists who have questioned AIDS orthodoxy, it is no wonder that others are nervous about making similar claims. When we at WHI began to think about some of these issues, we were very apprehensive about delving into this area, and particularly to entertain critiques of the HIV=AIDS connection. Grappling with these questions has not been easy, particularly in an environment where to ask a question, to express doubt, is tantamount to heresy. Still, even though at times we have felt insecure in our own course, we continue to ask the questions that need to be asked and seek answers that can increase our understanding.

We believe that debate and the investigation of alternative views of AIDS, its causes, treatment and prevention, are essential. It is through healthy debate that the most appropriate health policies are promoted, particularly where treatment involves toxic and experimental drugs.

Women's Health Interaction (WHI) is a voluntary feminist health collective based in Canada. This article first appeared in *African Agenda* (Vol. 3. No. 2).

Shifting definitions

CHARLES GESHEKTER **looks at how AIDS orthodoxies are perpetuated in Africa and notes that a remarkable imprecision about the definition of the syndrome and its causation has clouded the public's understanding of HIV and AIDS on the continent.**

Because Africa plays a major role in the alarming predictions about increased AIDS incidence, it is crucial to distinguish between a virus (HIV) and a syndrome (AIDS) in order to recognise how ambiguous definitions have helped to spawn misinformation about AIDS. Part of this problem arises from the alphabetic shorthands that are often used interchangeably: HIV, HIV disease, HIV infection, HIV/AIDS, AIDS, STD/AIDS, TB/AIDS, STD/TB/AIDS.

In July 1997, a regional health department in South Africa concluded that it was 'outdated and inaccurate' to say someone 'has AIDS'. Rather than distinguish between an HIV antibody test and an actual AIDS case, the Gauteng Health Department decided it would henceforth use the term 'HIV infection' to include every stage of infection and disease.

This critical shift in terminology usually is ignored in media accounts that predict African life expectancy or death rates based on projections of HIV infections. Discrepancies are also evident when comparing HIV and AIDS figures in the annual *World Health Reports* (issued by the World Health Organisation) and its *Weekly Epidemiological Record* (*WER*) with those used in a highly publicised and frequently cited *Report on the Global HIV/AIDS Epidemic* that was widely distributed at the International AIDS Conference in Geneva (June 1998).

In November 1998, the *WER* provided the totals of AIDS cases for a 15-year period (1982-1997) in the following countries: Nigeria (21,905); South Africa (12,825); Uganda (53,306); and Tanzania (97,621). The *World Health Report 1998* which claims to 'use the latest data gathered and validated by WHO' gives the following numbers of AIDS cases in those four countries for 1996: Nigeria - 308; South Africa - 729; Uganda -3,021; and Tanzania - 0.

When the *Report on the Global HIV/AIDS Epidemic* conflated the number of actual AIDS cases with the estimated number of Africans said to be HIV-positive, these were the results: Estimated number living with HIV/AIDS Nigeria 2.3 million; South Africa 2.9 million; Uganda 1.9 million; Tanzania 1 million.

By analysing the epidemiological data from studies that claim to show the sexual transmission of a virus thought to cause immune deficiency in Africa, this paper argues that conventional ideas about the viral causes of AIDS are not subjected to the same standards of verification used in the empirical sciences. For instance, a survey of adult mortality in Lusaka, Zambia cited the most frequently reported causes of death to be diarrhoea (20%), malaria or fever (9%), witchcraft (7%), tuberculosis (7%), and cough (6%). AIDS was given as the cause in 3% of deaths.

The researchers breezily concluded that since 'HIV seroprevalence in Lusaka is currently 25-30%, and given the unusual prominence of diarrhoeal disease as a cause of death, we believe that HIV infection is largely responsible for the high death rate'.

Before international donors pour more money into African AIDS research, or conduct another knowledge-attitude-practice survey, or advocate modifying anyone's sexual behaviour, they must subject their most basic suppositions about AIDS cases in Africa to the standards of consistency, testability and parsimony required in empirical science. Unless researchers concur on which surveillance methodology is used to carefully define a case of 'AIDS', they will disagree on substantive policy recommendations regarding AIDS prevention. It is important for African social scientists to gather data, weigh and interpret evidence and verify the accuracy of claims made by international AIDS experts.

Some prominent South Africans have begun to demand far more reliable data to show how HIV infection actually spreads via migrant labourers or truck drivers. The editor of the *South African Medical Journal*, Daniel Ncayiyana, questioned the uncritical way HIV and AIDS statistics are selectively gathered from women at antenatal clinics, then projected as representative of the entire country. He pointed out that a 'gaping discrepancy in prevalence between KwaZulu-Natal and the eastern Cape remains unelucidated' and wondered why the 'actual trail of infection from the city to rural areas has not been properly traced.' Answers to these and other questions may be found through a critical re-appraisal of HIV/AIDS research elsewhere in Africa.

Sex and AIDS

Millions of Africans have long suffered from severe weight loss,

HIV/AIDS diagnosis: raising more questions than answers.

African Agenda

chronic diarrhoea, fever and persistent coughs. In 1985, Western researchers suddenly defined this cluster of symptoms as a distinct syndrome, AIDS, and declared that it was caused by a single virus - HIV - which they alleged could be easily transmitted through sexual contact.

American health officials universally accept this HIV/AIDS model to explain what used to be considered the diseases of rampant poverty in Africa. There are at least three reasons why this view needs careful reconsideration.

First is the fact that many Africans who qualify for an AIDS diagnosis - perhaps as many as 70% - turn out to be negative when tested for HIV according to the Western Blot. Second is the failure of this African HIV/AIDS model to predict the course of AIDS in the United States.

Since AIDS symptoms are widespread in the general African population, if it transmits heterosexually it should also become widespread in other general populations, such as Americans, in which hundreds of thousands of heterosexuals annually contract venereal diseases.

Instead, 17 years after it was first described in the medical literature, in the United States, AIDS has remained rigidly confined to special risk groups. Of the 70,000 annual American AIDS patients, at least 90% are drug users (including nearly all the gay patients), and fewer than 10,000 are identified as heterosexual cases.

Third, sexual transmission cannot explain the differences in rates of HIV positivity between African (about five per 100) and American (about one per 7,000) heterosexuals. When the HIV/AIDS paradigm made its debut in 1984, its proponents assumed that HIV was easily transmitted coitally. Scientists only tested this idea ten years later, when they arrived at extremely low coital transmission frequencies. Researchers routinely classify 'HIV infection' as a sexually transmitted disease (STD) without acknowledging the extraordinary difficulty of alleged sexual transmission of HIV.

The latest studies by Nancy Padian and her associates demonstrate that the rate of ineffectiveness for male-to-female transmission is extremely low, 'approximately 0.0009 per contact', while female-to-male transmission is eight times less efficient.

In other words, an HIV-negative woman may convert to positive on average only after 1,000 unprotected contacts with an HIV-positive man. An HIV-negative man may become positive on average only after 8,000 contacts with an HIV-positive woman.

These data suggest two mutually exclusive conclusions. Either HIV is not a sexually transmitted microbe after all and other factors must account for HIV seroprevalence or African heterosexuals are wildly more promiscuous than American heterosexuals, a scenario that is surely not true, but does perpetuate centuries-old Western stereotypes.

With all of this in mind, why do so many health professionals and public health officials consider it useful or necessary to view the diseases of poverty in Africa as sexually contagious? And why did they ever believe it?

The Bangui Definition

How can one virus cause 29 heterogeneous 'AIDS indicator' diseases almost entirely among males in Europe and America but afflict African men and women in nearly equal numbers?

The answer is that the World Health Organisation uses a definition of AIDS in Africa that differs decisively from the one used in the West. The origins of the definition of African AIDS are quite illuminating.

Joseph McCormick and Susan Fisher-Hoch were physicians from the US Centers for Disease Control (CDC) who were instrumental in convening the WHO conference in the Central African Republic in 1985 that produced the 'Bangui Definition' of AIDS in Africa. The CDC had just adopted the HIV/AIDS model to explain immune disorders found among American drug injectors, transfusion recipients, and a cohort of promiscuous urban gay men. There was a tendency for HIV antibodies to react with plasma from these patients. The same was true of blood from Africans afflicted with the diseases of poverty. The infectious viral model of AIDS assumed that immune deficiency would 'spread' via HIV to a much larger faction of Africans than those who tested positive for the antibodies.

Doctors McCormick and Fisher-Hoch accepted this model, recently explaining their motivation for the Bangui conference and the rationale behind the AIDS definition that resulted from it as follows: 'We still had an urgent

need to begin to estimate the size of the AIDS problem in Africa .... But we had a peculiar problem with AIDS. Few AIDS cases in Africa receive any medical care at all. No diagnostic tests, suited to widespread use, yet existed .... In the absence of any of these markers [e.g., diagnostic T4/T8 white cell tests], we needed a clinical case definition .... a set of guidelines a clinician could follow in order to decide whether a certain person had AIDS or not. [If we] could get everyone at the WHO meeting in Bangui to agree on a single, simple definition of what an AIDS case was in Africa, then, imperfect as the definition might be, we could actually start to count the cases, and we would all be counting roughly the same thing.

'The definition was reached by consensus, based mostly on the delegates' experience in treating AIDS patients. It has proven a useful tool in determining the extent of the AIDS epidemic in Africa, especially in areas where no testing is available. Its major components were prolonged fevers (for a month or more), weight loss of 10% or greater, and prolonged diarrhoea.'

The doctors said they wanted to refute the ugly moralism of the 1980s that AIDS was a 'gay plague' by convincing the American government that 'AIDS was a plague all right, but that no one was immune.'

McCormick and Fisher-Hoch recalled that: 'Experts in STDs continued to regale us with tales of the excessive and often bizarre sexual practices associated with HIV in the West ... we were also beginning to see a direct correlation between the number of sexual partners and the rate of infection ... Compared to the West, heterosexual contacts in Africa are frequent, and relatively free of social constraints — at least for the men .... There was every reason to believe that, having found heterosexually transmitted AIDS in Kinshasa, we were likely to find it everywhere else in the world.'

It was upon these grossly unscientific claims, sweeping clinical generalisations, Western notions of sexual morality and 19th century racist stereotypes about Africans that AIDS became a 'disease by definition'.

More of the same

Africa was assigned a central role in promoting the premise that AIDS was everywhere and everyone was at risk. By 1986, 'people were falling over one another to get involved in AIDS research,' recalled the doctors. 'They realised that AIDS represented an opportunity for grant money, training, and the possibility of professional advancement .... A certain bandwagon mentality took hold. Careers and reputations were riding on the outcome'.

As proof that these 'AIDS symptoms' were sexually transmitted, McCormick and Fisher-Hoch relied on a narrow survey conducted by Kevin DeCock, another CDC epidemiologist.

DeCock examined stored blood samples taken in 1976 (for Ebola virus testing) from 600 residents of the small town of Yambuku, in northern Zaire. Samples from five patients (0.8%) tested positive for HIV antibodies.

DeCock wanted to know what happened to those five people during the intervening ten years. According to McCormick and Fisher-Hoch: 'Three of the five were dead. To determine if their deaths were attributable to AIDS, Kevin interviewed people who had known them. The friends and relatives of the deceased described an illness marked by severe weight loss and other ailments that left little doubt in Kevin's mind that they had succumbed to AIDS.'

DeCock concluded from these interviews that the dead subjects had died from AIDS, and that HIV had caused their death. He reached this conclusion without properly matching the five HIV-positive patients with peers from among the 595 HIV-negative subjects and without collecting mortality data and morbidity information about them either. Had he done this, perhaps he would have discovered that numerous HIV-negative Africans die of 'severe weight loss' and other so-called AIDS conditions.

DeCock further noted that antibody tests conducted in 1986 showed that the HIV prevalence in Yambuku had remained constant at 0.8% during the ten years since 1976. As far as he was concerned, this meant that HIV — and thus AIDS — really did originate in Africa. HIV (AIDS) existed for years in small numbers of rural inhabitants who had contracted the HIV from primates, he imagined. He speculated that once some of those people in the late 1970s migrated to what DeCock falsely assumed were sex-crazed cities, an epidemic of HIV and AIDS exploded. DeCock did not consider that these same data could have been interpreted as indicating that HIV is a mild virus, and difficult to transmit. Neither did McCormick and Fisher-Hoch.

The sort of presumptive diagnosis employed by DeCock is known as a 'verbal autopsy'. It is widely accepted in Africa, where 'no country has a vital registration system that captures a sufficient number of deaths to provide meaningful death rates'.

While medically certified information is available for less than 30% of the estimated 51 million deaths that occur each year worldwide, the Global Burden of Disease Study (GBD) found that sub-Saharan Africa had the greatest uncertainty for the causes of mortality and morbidity since its vital registration figures were the lowest of any region in the world - a microscopic 1.1%.

These 1997 findings prompted *The Lancet* to acknowledge editorially that 'current strategies to improve the world's health may need to be reassessed' and to ponder 'how much more money is spent on research into HIV infection than into the causes of suicide or the prevention of road-traffic accidents and why should this be'.

Charles Geshekter is with the Department of History, California State University, USA. The article was first published in *African Agenda* (Vol. 3, No.2), the magazine produced by the African Secretariat of the Third World Network. *contact@twnafrica.org*

Africa and the virus of underdevelopment

Rahab S Hawa

The South African President's views on HIV/AIDS are further examined in the context of the social and economic conditions that prevail in Africa and the international power structures that continue to chart Africa's course.

In 2000, South African President Thabo Mbeki came under sustained attack from both the scientific community and his allies concerning his response to the AIDS epidemic. Of course, the world media had a field day reporting it.

President Mbeki was accused of sowing confusion over AIDS when he insisted that AIDS was linked to poverty.

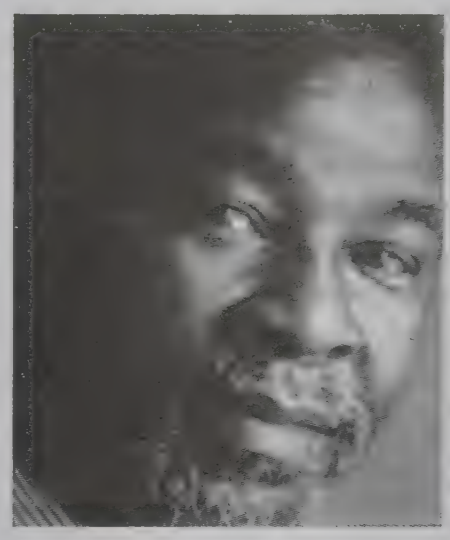
In his speech to the 13th International AIDS Conference in Durban, he said: 'What I heard was that extreme poverty is the world's biggest killer and the greatest cause of ill health and suffering across the globe. I heard stories being told about malaria, tuberculosis, hepatitis B, HIV/AIDS and other diseases.'

'As I listened even longer to this tale of human woe, I heard the name recur with frightening frequency – Africa, Africa, Africa,' he added.

'In the end, I came to the conclusion that as Africans, we are confronted by a health crisis of enormous proportions. One of the consequences of this crisis is the deeply disturbing phenomenon of the collapse of immune systems among millions of our people, such that their bodies have no natural defence against attack by many viruses and bacteria,' he said.

'As I listened and heard the whole story told about our own country, it seemed to me that we could not blame everything on a single virus,' he continued.

'The world's biggest killer and the greatest cause of ill health and suffering across the globe, including South Africa, is extreme poverty'.



President Thabo Mbeki of South Africa

Thabo Mbeki was not alone when he said this. Years earlier, the late Jonathan Mann (who became the founding director of the WHO's Global Programme on AIDS) had made the link between deprived social and economic conditions and vulnerability to AIDS in his pioneering work on the AIDS epidemic in Africa.

'Those people who were marginalised, stigmatised and discriminated against — before HIV/AIDS arrived — have later become, over time, those at highest risk of HIV infection,' he wrote.

As a result of his AIDS research from 1984-1986 in Zaire, he warned that AIDS was not merely another infectious disease. 'It seemed to flourish in and reinforce conditions of poverty, oppression, urban migration and social violence'.

According to a *Washington Post* article dated 5 July 2000, just before his death in a plane crash on 3 September 1998, Mann said, 'Discrimination isn't just an effect, it's actually a root cause of the epidemic itself'.

These conditions have prevailed in Africa ever since it was called upon to follow the prescriptions dished out by the World Bank and the International Monetary Fund.

Over the past four decades, South Africa's apartheid legacy and inequalities, the collapse in commodity prices, debt repayments and structural adjustment programmes and conditionalities have consigned Africa to the margins of the global economy, and virtual collapse.

The poverty virus

African countries are worse off today than they were during their independence in the 1960s. This was stated in a July 2000 report prepared jointly by the World Bank and its partners, entitled 'Can Africa Claim the 21st Century', which makes grim reading.

In the early 1960s, African nations were widely considered to be more advanced than East Asian nations. But between that time and the end of the 1990s, Africa retreated in real economic terms.

Over the past 30 years, it has lost market shares in global trade even in primary goods. 'Africa accounts for barely 1 percent of global GDP and only 2 percent of world trade,' says the report. 'Its share of global manufactured exports is almost zero'.

Nearly half the continent's people live below the poverty line. Less than one in five Africans have access to electricity; two-thirds of rural people lack adequate water supplies; and three-quarters live without proper sanitation.

Infectious diseases like malaria and AIDS take more of a toll now than at any time since the early part of the 20th century.

The UN Economic Commission for Africa had stated that the World Bank's structural adjustment policies have increased poverty and

unemployment.

'Debt servicing obligations have become unbearable ... starvation and malnutrition, abject poverty and external dependence have worsened, while other structural weaknesses and deficiencies of the African economies have intensified,' it noted in a 1989 report.

According to UNDP's 1999 *Human Development Report*, the debt burden has undermined growth, health and education.

These colonial legacies have looted and reduced the continent to a state of poverty, conflict, chaos, criminality and disease. Many African nations have ceased to exist; law and order have all but disintegrated, plunging countries into bottomless pits of inter-ethnic genocide, wars, mayhem and murder; while natural disasters, death and ruin are unprecedented.

Poverty and conflict feed on each other. Clare Short, Britain's former International Development Secretary, said at a London Conference in March 2001 that 'Africa will not escape a cycle of poverty and decay without peace and stability'. Peace and stability can only come about when there are resources available to secure social and economic stability.

By the end of 1998, the total debt burden had reached 65.5 percent of the GDP; and some countries spend 40 percent of their national budget on debt servicing. The debt service obligations of African countries are a major obstacle to social and economic development.

This was implicitly acknowledged by the head of UNAIDS, Peter Piot, at the Durban AIDS Conference, when he called for the cancellation of the entire foreign debt of the African countries to enable them to develop public health capacities to fight the pandemic. Developing countries that carry some 95 percent of the AIDS burden have a debt of more than $2 trillion. The $15 billion or more in interest payments per year that poor countries have to pay can be used instead for social and economic development.

So far, attempts by the industrialised creditor nations to relieve (not cancel) these countries of their

HELLO, IS THAT THE DEVELOPED WOR
LISTEN, WE CAN'T START CONSTRUCT
TILL YOU REMOVE WHAT YOU LEFT
OUR SITE.

debt burdens have turned out to be public relations stunts with rock stars in tow.

Even the WB-IMF's highly touted debt relief plan, the Heavily Indebted Poor Countries (HIPC) Initiative, has been found to be a sham, benefiting the creditors rather than the debtors.

In a letter to the *Financial Times* dated 29 September 2000, Kevin Watkins of Oxfam said that eight countries – including Mozambique, Malawi and Senegal —spend more than 15 percent of revenue on debt servicing, with this rising to 40 percent in Zambia. In Tanzania, post-HIPC debt servicing amounted

More salt to the wound

In 1998, key figures from the international health community confronted the World Bank detailing the extent and nature of the AIDS epidemic. Out of this came the Bank's document *Intensifying Action Against HIV/AIDS in Africa. Responding to a Development Crisis*. In it the Bank acknowledged its special leadership role in fighting the epidemic and the need for it to be held accountable for its stewardship.

As part of that response the Bank started the Multi-Country HIV/AIDS Programmes (MAP) for Africa with $1 billion committed to 24 countries. The Bank launched a $500 million loan facility for Africa in 2001.

However, this loan facility has sparked outrage. The loan extended through the Bank's concessional lending arm – the International Development Association (IDA) — according to critics, is rooted in the Bank's Country Assistance Strategies, which make assistance conditional on economic reforms set by the Bretton Woods Institutions.

Others have drawn attention to the fact that fighting HIV/AIDS is not an income-generating project and say that it is immoral to finance such efforts through interest-bearing loans.

At the 2nd annual African Development Forum of the UN Economic Commission for Africa (ECA) in 2000, Debrework Zewdie, the Bank's lead HIV/AIDS coordinator, in an effort to sell their plan, 'explained that it was wiser to spend borrowed money on HIV/AIDS prevention programmes now than having to spend more at a later stage. 'The choice is stark and simple. Pay now, or pay more later,' she said.

The Bank has already committed more than $1 billion to HIV/AIDS projects in 56 countries around the world, and will continue to be a big player as more cash-strapped countries turn to it in the face of the growing epidemic. It is one of the seven bodies which make up UNAIDS, the others being UNICEF, UNDP, the UN Population Fund, UNESCO, WHO and the UN International Drug Control Programme.

In response, a youth delegate at the Forum said that by providing loans to a continent that cannot afford to repay existing debts, the Bank is further tightening the noose around the necks of African countries with stagnating economies.

Michael Kelly, a Zambian economist, proposed that rather than saddling Africa's future generations with more debt, the Bank might instead use its influence to pressure the drug multinationals that are resisting efforts by African countries to import or manufacture cheaper generic versions of their expensive patented medicines.

To applause from the delegates, he told the Bank: 'Down the line, you can start squeezing these companies as you have been squeezing us all these decades'.

Based on **Gumisai Mutume**, 'African leaders declare war on AIDS', *Africa Recovery,* January 2001

to $177 million, while current spending on primary education and health was $136 million.

According to the Southern African Research and Documentation Centre (SARDC), 22 of the 41 HIPC on the debt relief scheme will still have to pay $2 billion a year to creditors, thus spending more on debt than on education and health.

'For every $1 that rich countries lend to the developing countries, $8 comes straight back in the form of repayment on debts owed to the rich countries,' says Archbishop Njongokulu Ndungane of Cape Town. 'Wealth is actually pouring from the South to the North,' he added. (See Box 'How Africa Develops Europe and the rest of the world'.)

The UN estimates that 19,000 children die each day as a result of the social impact of the debt. The UNDP estimates that seven million children's lives in sub-Saharan Africa could be saved each year, if the money currently spent on debt servicing was channelled to health and education.

In the face of ballooning debts, crippling loan conditionalities and stagnating economies, the rich countries were cutting back on aid to these indebted countries. Aid to sub-Saharan Africa fell from 32.9 percent in 1993-94 to 29.6 percent in 1998-99, further retarding its development.

The AIDS pandemic which threatens to destroy the entire African continent has to be seen in the context of the forces that have shaped the social realities and produced the conditions that confront Africa today.

The impact of colonialism and the market economy which have transformed African society and the traditional family system and created the migrant labour system, urban migration, landlessness, environmental degradation, pauperisation, gender inequality and discrimination, and conflicts which were further intensified with the debt and economic crises and structural adjustments imposed by the WB-IMF which have eroded the social gains of the African countries since independence; sets the backdrop for the AIDS epidemic.

The AIDS burden

Many of the HIPC are facing a

How Africa develops Europe (and the rest of the rich world)

In order to understand Africa's relationship with the developed world, it is important to look at figures which show that, far from contributing nothing to the economy of developed countries and taking everything in return, Africa's contribution to developed countries could be considered as its own form of development aid.

According to Jubilee Research, the accumulated external debt of the world's richest country, the USA, is $2.2 trillion - almost the same as the $2.5 trillion owed by the entire developing world including India, China and Brazil. They calculate that this means that every American citizen owes the rest of the world $7,333 while every citizen of all the developing countries only owes the rest of the world $500.

Meanwhile the poor are financing the debt of the developed world, as capital flows from poor countries, helping to lower rich countries' interest rates and inflate the value of their currencies, enabling them to purchase goods from the rest of the world far more cheaply than they would otherwise have been able to do.

The United Nations Development Programme (UNDP) calculated that by 1987 nearly one-third of Africa's skilled people had moved to Europe - Sudan lost 17% of doctors and dentists, 20% of university teaching staff, 30% of engineers and 45% of surveyors in 1978; 60% of Ghanaian doctors trained in the early 1980s are now abroad; and Africa as a whole is thought to have lost up to 60,000 middle- and high-level managers between 1985 and 1990.

This reverse subsidy seems set to continue. Some estimates indicate that mechanistic and flawed developed-country staff forecasting needs mean that the USA, for example, will require 1 million additional nurses in the next 10 years to meet its shortfall.

Writers on human resources such as Bundred and Martineau put the cost of training a GP as $60,000, calculating a reverse subsidy from the developing world of US$500 million per annum just for health personnel. In South Africa alone, the loss of more than 82,000 skilled personnel over an eight-year period between 1989 and 1997 is estimated to have cost the country $5 billion. The UN Conference on Trade and Development (UNCTAD) quantified US savings of $3.86 billion in training costs as a result of importing 21,000 Nigerian doctors over a 10-year period.

Central to these startling statistics are structural adjustment programmes. Structural adjustments demanded that, as a precondition to receiving aid, developing countries open their markets to globalisation and privatise their utilities such as water and electricity services. Among the other requirements were tightening of state expenditure and devaluation of currencies, resulting in an end to free health and education and dramatic cutbacks in these services.

The withdrawal of resources for education and health initiated a cycle of deprivation in which working conditions, including salaries, deteriorated, triggering an exodus of staff and further debilitating the services. Simultaneously, funding of academic training institutions was reduced, and there was a concurrent flight of intellectuals and decimation of institutions of higher learning. Philip Altbach calculates that roughly 1.5 million students (most of whom leave the South to study in the North) study in countries outside their own, and a significant number do not return.

The net effect has been to strip countries of a significant component of their social capital and create a vacuum of skill, conveniently providing jobs for highly trained Westerners (to be paid for in hard currency) and simultaneously the conditions for Africa to be reduced to providing technical-level education and producing a workforce only fit to do the dirty jobs of the rich world.

— **Antoinette Ntuli**, *Pambazuka News* (No. 139, 15 January 2004, *www.pambazuka.org*)

devastating AIDS crisis. At the Durban AIDS Conference, Karen Stanecki of the US Bureau of Census revealed figures that sent shockwaves around the world.

According to her estimates, people in four African countries, namely Zimbabwe, Namibia, Swaziland and Botswana, will have an average life span of only 29-33 years; whilst in many other African countries, average life spans will be below 40 years.

By 2003, some African countries, including South Africa, would have negative population growth, she said.

According to her, 20 percent or more of the adult population in Botswana, Lesotho, Namibia, South Africa, Swaziland, Zambia and Zimbabwe are infected with AIDS.

The World Bank economist for Africa, Alan Gelb, says that AIDS has been even more devastating than the numbers suggest, as the disease is most likely to infect young adults entering the most productive period of their lives. He said this at the launch of the World Bank Report in July 2000.

AIDS, in turn, will have a devastating impact on the economies of countries. According to Gelb, in the worst-affected African countries, labour markets have been crippled, national savings rates have declined, and economists are forecasting severe shortages of skilled manpower, as an entire generation is depleted by the epidemic.

And AIDS is spreading at a rate that was unimaginable in the mid-1990s. There are now 25 million AIDS cases in Africa. More than 8 million African children have become 'AIDS orphans'.

The social and health crises unfolding in Africa are linked to the debt crisis (and growing poverty) afflicting the continent.

The ongoing immiserisation of Africa and the systemic crises that confront the continent, resulting in the collapse of social and public health and delivery systems, the ensuing social dislocation and unrest, are a leading factor in the AIDS pandemic.

These are ideal conditions for the spread of ill health, diseases, death and epidemics. It is little wonder that AIDS has exploded in Africa, killing almost two-and-a-half-million people in 2000, whereas 200,000 Africans died in wars in 1998.

According to UNAIDS, the disease is intensifying in Russia, Eastern Europe, India and Latin America – areas that are under enormous social and economic stress and instability where state welfare (and health) systems have collapsed.

Can the exponential leap in the AIDS epidemic worldwide be attributed mainly to sexual behaviour, as it is claimed that AIDS is largely a sexually transmitted disease?

Where's the dough?

In the light of the impending catastrophe that awaits Africa – drastically shortened lifespans and negative population growth due to severe escalating death rates from AIDS, and economic collapse — the US and the industrialised nations spend less than one percent of their overseas development budgets on AIDS.

This was revealed in a UN study in 1999, which showed that the rich countries spend $350 million to fight AIDS but their spending was not in keeping with the spread of the disease.

According to a press report dated 23 April 1999, the UNAIDS Director was quoted as saying: 'Twenty years into the epidemic ... AIDS is expanding three times faster than the funding to control it. Weighed against the global catastrophe of the AIDS epidemic, level of spending for HIV is minimal.'

'Donor nations must realise that their substantial investments towards improving conditions in developing nations will be effectively obliterated unless more is invested in fighting AIDS – the single greatest threat to global development today,' he warned.

UNAIDS says that AIDS funding in Africa alone will require more than $3 billion per year and only a fraction of this amount is available. It realises that one of the major obstacles in the battle against AIDS is the lack of funds.

The Global Fund to Fight AIDS, Tuberculosis and Malaria created in 2002 requires, by 2005, $10 billion per annum to fight AIDS. So far it has been able to hand out $2 billion over two years.

At the UN General Assembly debates in September 2003, Juan Manuel Suarez del Toro, the President of the International Federation of the Red Cross and Red Crescent Societies, pointed out that it was 'an ethical duty for Member States to contribute' to the Global Fund. The $10 billion agreed to under the Declaration of Commitment in 2001 (that set concrete goals for containing the spread of HIV/AIDS and aiding its victims) represented only $250 per infected person over three years, which is less than $1 a day.

Kofi Annan, the UN Secretary-General, said that 'at the current rate of progress, none of the agreed targets would be met.' Lamenting the fact that money was not forthcoming, Annan, in a BBC interview which was posted on the BBC's website on 28 November last year, had this to say: 'I feel helpless to live in a world where we have the means, we have the resources to be able to help all these patients, and what is lacking is the political will ... If we do not replenish the funds and the Global Fund were to fail it would be a very serious indictment of the leadership in the world today'.

However, WB-IMF policies are still in place that continue to impose strict conditionalities and force poor countries to go on paying their debts as more loans are offered for AIDS (see Box 'More salt to the wound').

HIV/AIDS fuelled by debt and IMF-World Bank policies

Africa Action

HIV/AIDS is the worst health crisis the world has ever seen. Since its discovery two decades ago, more than 25 million people have died of AIDS. At present, there are more than 42 million people living with HIV/AIDS worldwide.

Africa is 'ground zero' of the global AIDS pandemic. Home to just over 10% of the world's population, sub-Saharan Africa has more than 75% of the world's HIV/AIDS cases. While HIV/AIDS is a global threat to human security that does not respect borders, it is taking its most devastating toll in Africa. Africa's people have been most vulnerable because poverty and inadequate access to health care services have fuelled the spread of HIV/AIDS. At the same time, the policies of the US government and the practices of the World Bank and the IMF have blocked Africans' own initiatives to fight HIV/AIDS.

While many African countries succeeded in improving their health care systems in the first decades after independence, the intervention of the World Bank and IMF reversed this progress. Investments in health care by African governments in the 1960s and 1970s achieved improvements in key health indicators. However, health indicators throughout Africa have fallen dramatically over the past two decades as a result of the HIV/AIDS crisis and other poverty-related diseases. Africa's health care systems have been unable to cope with the crisis because of economic policies imposed by the World Bank and IMF, forcing cutbacks in public health and reducing access to basic services (see box). The result has been that much of the progress made in Africa's early post-independence years has been undone. Average life expectancy in Africa has fallen by 15 years in just the past decade. AIDS is now the leading cause of death in sub-Saharan Africa.

As African countries struggle to cope with the impact of HIV/AIDS, their efforts are undermined by the massive amounts of money they must pay to foreign creditors each year. Africa currently spends $15 billion a year in debt servicing,

Healthcare becomes a commodity

In 1993, the World Bank used its annual World Development Report to further articulate its market-driven designs for health care delivery and finance. That report, *Investing in Health*, recognised that poverty is a threat to health, but did not address the issue of economic inequality and poor health. It stated that economic growth is a condition for good health, and that countries must first improve their economic growth rates before they can significantly increase spending on health.

When the IMF tells a country it must reduce public spending in order to get loans and credit, health ministries are among the first to get their budgets cut. The cumulative effect of 20 years of chronic underfunding is the dilapidated state of many public health systems today – a disaster as the HIV/AIDS crisis continues to accelerate. In an effort to improve government spending in health, the World Bank calls for trimming government spending by reducing services from comprehensive coverage to a narrowly selective, cost-effective approach or a new type of selective primary health care. This has resulted in the World Bank's promotion of 'user fees' - having clinics and hospitals charge poor people fees for services that used to be free. These fees had the perverse effect of preventing or discouraging many from using clinics at all.

For instance, when the World Bank mandated that Kenya impose charges of US$2.15 for patients, at Nairobi's Special Treatment Clinic for Sexually Transmitted Diseases (STDs) it resulted in a decrease in attendance of 40% for men and 65% for women over a nine-month period. Failure to treat STDs can significantly increase the likelihood of transmission of HIV/AIDS. Similar results, drops in attendance of 35 to 60%, have been seen throughout the developing world. And in a January 2000 United Nations Children's Fund (UNICEF) paper *Absorbing Social Shocks, Protecting Children and Reducing Poverty*, which quotes a study in Zambia, a researcher witnessed the arrival of a 14-year-old boy at a hospital, suffering from acute malaria. His parents were unable to pay the registration fee of ZK300 (33 cents US) and the boy was turned away. The report added that 'within two hours the boy was brought back dead'.

In what it calls 'promoting diversity and competition in health services', the World Bank seeks to increase the role of private doctors and businesses to deliver and finance most of those government services that were once subsidised or provided free to the impoverished. This moves money out of the public health care system and into the private sector, further depriving the public health system of funding. It moves forward the process of privatisation of most medical and health services, and prices many medical interventions beyond the reach of the poorest people. — **50 Years Is Enough Network**. Reproduced from *Empty Promises: The IMF, the World Bank and the Planned Failures of Global Capitalism.*

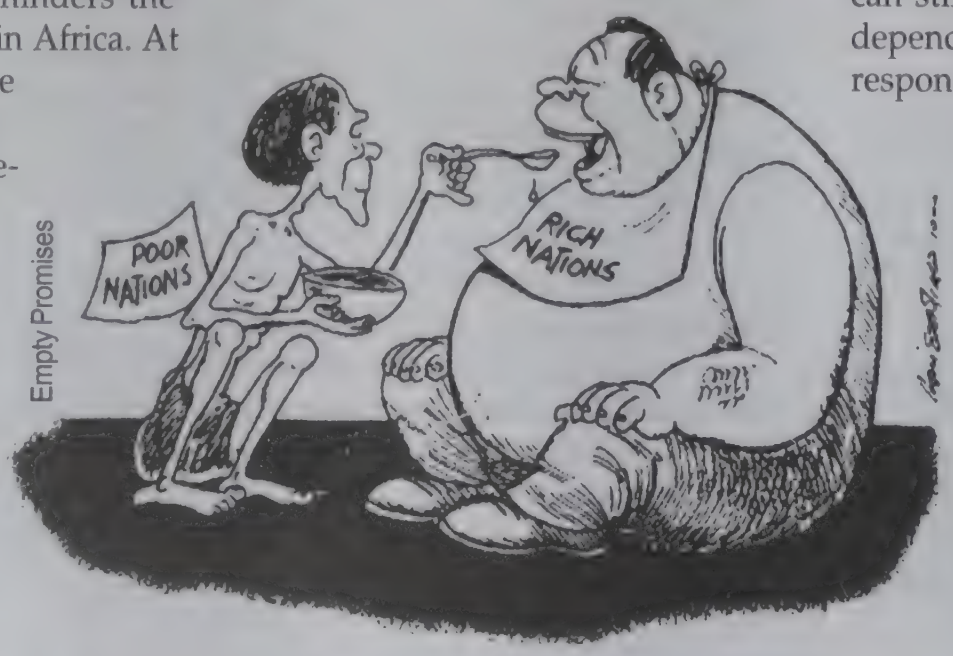
Empty Promises

according to the United Nations, yet sub-Saharan Africa needs $10 billion a year to effectively fight the HIV/AIDS pandemic. The US and other rich-country governments, and the World Bank and IMF, continue to insist that African governments repay old, illegitimate debts to them, even while these debts divert desperately needed resources from spending on health care and on the fight against HIV/AIDS. Despite creditors' promises of debt relief, most African governments still spend more money each year on debt service than on health care for their own people. Africa's burden of illegitimate external debt is a major obstacle to the continent's efforts to defeat HIV/AIDS.

Inadequate access to essential treatment and care also hinders the fight against HIV/AIDS in Africa. At present, only 1% of those living with HIV/AIDS in Africa have access to life-saving drugs that have cut death rates so dramatically in the US and elsewhere. While the prohibitive cost of anti-AIDS drugs and the restrictive trade rules that have kept them out of reach for Africans have come under challenge recently, huge obstacles to treatment access still remain. The US government continues to support the efforts of the big pharmaceutical companies to keep their profits high, at the expense of African lives. Its policies block African governments' efforts to acquire affordable medicines, including generic drugs, through entirely legal international trade provisions, such as compulsory licensing and parallel imports.

Throughout Africa, organisations and activists are struggling to prevent the spread of HIV/AIDS and to provide care to those already living with the disease. But their efforts are hindered by international obstacles and by insufficient resources. The recently established Global Fund to fight HIV/AIDS can provide the necessary support to effective prevention and treatment programmes in Africa and other poor regions. However, the crucial work of the Global Fund is being undermined by inadequate funding from the US and other rich countries.

HIV/AIDS is the greatest global threat that exists today, and the pandemic is still in its infancy. The continued spread of this disease threatens the future of entire economies and countries, and has serious implications for global stability. International inequalities and global racism have defined the pattern of the HIV/AIDS pandemic and continue to circumscribe the global response. The war on AIDS can still be won. But victory will depend on a successful effort to respond to the crisis first and foremost in Africa, the epicentre of the pandemic.



Empty Promises

Reproduced from *Empty Promises: The IMF, the World Bank, and the Planned Failures of Global Capitalism.*

Africa Action is the oldest group in the US working on African Affairs

Public health versus commercial interests

The role of public interest groups in Thailand

Nathan Ford, David Wilson, Onanong Bunjumnong, Tido von Schoen Angerer

Drawing on key interviews and published reviews, the authors trace the efforts of Thai health activists and public interest groups to achieve a fair balance between international trade and public health. These efforts have focused on didanosine, an essential antiretroviral drug that in Thailand has become symbolic of how multinational companies and governments of industrialised countries protect their own interests at the expense of access to essential medicines for the poor.

In October 2002, two Thai people with HIV-1 won an important legal case to increase access to medicines. In its judgment in the didanosine patent case against Bristol-Myers Squibb, the Thai Central Intellectual Property and International Trade Court ruled that, because pharmaceutical patents can lead to high prices and limit access to medicines, patients are injured by them and can challenge their legality.

This ruling had great international implications for health and human rights, confirming that patients—whose health and lives can depend on being able to afford a medicine—can be considered as damaged parties and therefore have legal standing to sue.

The complexities of pharmaceutical intellectual property law are most poorly understood by those most affected by their consequences - the patients who need the drugs. The Thai court case was the outcome of a learning process and years of networking between different civil society actors who joined forces to protect and promote the right of access to treatment.

Early efforts to provide treatment

Thailand is a low-to-middle-income country with a population of 63·5 million, of whom about 603,000 have HIV/AIDS (adult infection rate is 1·8%). The country is noted for an effective response to the epidemic. The Thai Public Health Ministry began to provide antiretroviral monotherapy in 1992 and dual therapy in 1995 for an estimated 25% of symptomatic patients attending public hospitals.

However, in 1995 specialists concluded that continuing the programme would be costly with minimum effectiveness, although their analysis did not take into account the possibility of lower prices due to generic competition or of the greater effectiveness of triple therapy.

In 2000, the Public Health Ministry began to promote triple therapy as the norm, using mostly brand-name drugs. However, coverage was limited by the price of medicines.

For several years, the only antiretroviral drugs commonly available in Thailand were zidovudine and didanosine. By 1996, generic zidovudine was available at a reasonable price, but generic production of didanosine was blocked by the patent holder Bristol-Myers Squibb (see sidebar) and the brand drug cost more per month (US$136) than the average wage of an office worker (US$120).

Since 1975, the US pharmaceutical industry has claimed that lack of product patents acts as a barrier to market entry in Thailand, and the US government has put trade pressure on the country to introduce stronger patent protection through trade sanctions, representing US$165 million in lost export revenue for Thailand.

In response to this pressure, Thailand has introduced a series of measures which maximise the rights of the multinational pharmaceutical industry while minimising the rights of patients, with little benefit to the national industry in terms of foreign investment and technology transfer.

Civil society groups are strong and numerous in Thailand, and have been central to defending and promoting access to medicines. In 1999, the Didanosine Working Group was formed as a result of concern about Thailand's patent laws, which they believe constituted a major barrier to access to HIV/AIDS drugs, a view confirmed by the findings of a joint UNAIDS/WHO fact-finding mission to Thailand in 1999. The mission recommended that the Public Health Ministry review its patent provisions on compulsory licensing and institute a means of monitoring drug prices, with assistance from WHO.

In November 1999, the Thai Government Pharmaceutical Organisation (GPO) submitted a request for a compulsory licence (a legal measure that allows governments to over-ride patents and produce generic medicines) to the Thai Department of Intellectual Property. This request was supported by several local non-governmental organisations, by the Thai network of people living with AIDS, and by Médecins Sans Frontières (MSF).

The occasion represented the first in Thailand when people infected with HIV braved stigmatisation to stage public demonstrations, and proved to be a watershed event in terms of awareness and self-confidence for people with HIV/AIDS.

At the same time, US AIDS activists demonstrated in Washington, DC against Bristol-Myers Squibb and the US government regarding their repressive trade policy with respect to drugs for HIV in Thailand and South Africa.

A letter from the US Ambassador in Bangkok to the US Trade Representative stated that the Thai government 'certainly don't want to be the cause of a trade dispute just before the Seattle Meeting [1999 World Trade Organisation (WTO) Ministerial], which is what we have always told them would happen if the compulsary [sic] licensing clause should be invoked'. The USA was concerned that this would 'set a worrisome precedent for the rest of the drug industry'.

In January 2000, Thai activists submitted a letter to the US government demanding that they not retaliate with trade sanctions if a compulsory licence was issued. This correspondence was backed by the Washington-based Consumer Project on Technology. The US government responded, 'the United States will raise no objection, provided the compulsory license is issued in a manner fully consistent with . . . TRIPS [trade-related aspects of intellectual property rights]'.

But this reply did not assuage fears of US trade retaliation. A senior official at the commerce ministry said, 'Thailand has committed to the international community not to use poverty and sickness as an excuse in international trade'. He expressed concern that, 'if a compulsory license were to be issued, just one million people will benefit, while the rest of the country's 61 million people will have to pay the price if the US retaliates.'

The use of compulsory licensing was rejected. Instead, the GPO began to produce a non-patented formulation of didanosine - a citrate-phosphate buffer formulation with more gastrointestinal side-effects than the patented drug.

Bristol-Myers Squibb taken to court

A lawsuit was filed in May 2001 at the Thai Central Intellectual Property and International Trade Court by the AIDS Access Foundation (a Thai foundation that provides social support to people with HIV/AIDS) and two patients with HIV against Bristol-Myers Squibb. The plaintiffs alleged that Bristol-Myers Squibb and the Thai Department of Intellectual Property had 'conspired to intentionally delete' the dose restriction to the didanosine patent (see sidebar). The court summoned the Department of Intellectual Property as a co-defendant.

One of the central questions in the case became whether individuals have the right to challenge a patent. The defendants claimed that the plaintiffs 'do not have the objective to manufacture didanosine, and can choose other medicines to cure the disease, and are therefore not injured or interested parties'.

However, in the final verdict, the court noted that 'Medicine is one of the fundamental factors necessary for human beings, as distinct from other products or other inventions that consumers may or may not choose for consumption' and that 'lack of access to medicines due to high price prejudices the human rights of patients to proper medical treatment'.

The court went on to assert the primacy of human life in trade agreements, as recognised internationally at Doha where 'it was insisted that TRIPS be interpreted and implemented so as to promote the rights of members to protect public health, especially the promotion and support of access to medicines'. This occasion is believed to be the first time a court decision has used the Doha Declaration to protect public health and the rights of patients. It concluded that 'injured parties . . . are not limited to manufacturers or sellers of medicines protected by patent. Those in need of the medicine are also interested parties to the granting of the patent.' The AIDS Access Foundation was also noted as an interested party, affirming the important role of civil society groups.

Furthermore, the court noted that the removal of the restriction on dose range extended the patent protection beyond the scope of the initially described invention. The court ruled this amendment unlawful.

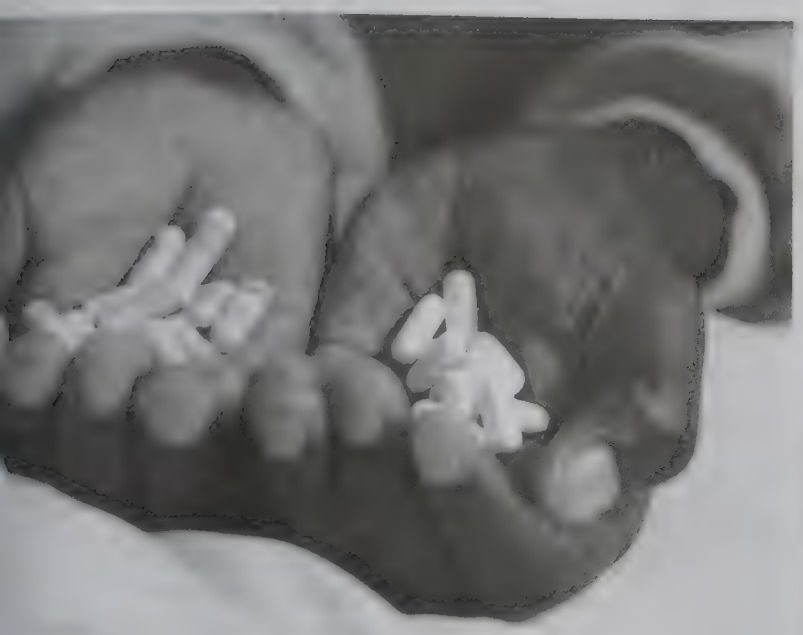
This ruling has set an important precedent that essential drugs are not just another consumer product but a human right, and that patients are injured by patents. The defendants initially appealed, but withdrew this appeal in January 2004.

Unsurprisingly, the parties involved had different views of the outcome. Although a spokesperson for BMS claimed they had decided to 'dedicate the patent to the people of Thailand', one of the plaintiffs said that 'this did not happen because the drug company wants to be kind to people living with HIV/AIDS in Thailand. It is the result of our fight to improve access to medicine'.

Thailand and beyond

The Thai Public Health Ministry has clearly stated that their ambitious antiretroviral treatment programme would not exist without generic drugs. The GPO produces seven antiretroviral preparations, which are two (nevirapine) to 25 (stavudine) times cheaper than the cheapest brand equivalents.

The use of locally produced generics has allowed the government's treatment programme to expand more than eight-fold in the past three years with only a 40% increase in budget. As of May 2003, 13,000 patients were receiving antiretroviral treatment; coverage is planned to increase to 70,000 people, using funds from the Thai government and from the Global



World Health Report

Fund to Fight AIDS, Tuberculosis, and Malaria.

Thus almost 10% of people with HIV/AIDS in Thailand will receive treatment within two years; most of those in need of antiretroviral treatment, according to the Public Health Ministry.

By 2005, developing country WTO members must implement the TRIPS Agreement in full. Without the effective use of safeguards to ensure generic competition, the cost of all new medicines will largely depend on price setting by the patent holder.

The Thai didanosine patent is an example of the problems faced by developing countries, and intergovernmental organisations, such as the World Intellectual Property Organisation (WIPO), should be more active in helping them to overcome the formidable challenges in implementing patent protection, including examining patent applications properly.

Countries also need assistance in meeting their obligations under the Doha Declaration and in implementing the TRIPS Agreement in a way that protects public health and promotes access to medicines for all. The TRIPS Agreement contains safeguards to protect public health, but in practice developing countries face political and practical obstacles to using these safeguards. In Thailand, the government has faced considerable trade pressure from the USA, and public health has suffered as a consequence.

World Health Assembly resolutions in May 2003 strengthened WHO's mandate to promote policies that increase the availability of generic medicines. WHO and WIPO should provide technical expertise to countries in the developing world with respect to the inclusion of effective public-health safeguards in national patent laws.

The constraints faced by countries in implementing these recommendations are exemplified by the fact that none of the recommendations of the 1999 UNAIDS/WHO fact-finding mission to Thailand, restated by a second UNAIDS/WHO mission in 2000, has been implemented.

In Thailand, civil society groups have been key to establishing the human right to health by challenging the practices of the multinational pharmaceutical industry and governments of industrialised countries. However, there are few developing countries where civil society is strong in advocating for greater access to medicines (Brazil and South Africa are notable exceptions).

Access to medicines for people in poorer countries risks being limited by monopolies, arising from over-restrictive patent laws and invalid but unchallenged patents for some time to come.

The pharmaceutical industry will continue to push for increased patent protection. In Thailand, successful opposition has come from people with HIV/AIDS, who have fought for their rights by forming effective coalitions, bringing together a range of experience and expertise.

Their experience has not only increased access to treatment, but has brought wider benefits in terms of self-image, confidence, and dignity of people with HIV/AIDS. Thailand's example can only be encouraged.

— *The Lancet* (Vol. 363, 14 February 2004, www.thelancet.com)

Privatisation of a Public Drug

♦ **February 1988** — US National Institutes of Health (NIH), which invented didanosine, grants a licence to Bristol-Myers Squibb (BMS) to produce the drug in a limited list of countries, excluding Thailand, for an initial period of 10 years, with option of 5-year extension. Licence includes fair-pricing clause, stating that 'there be a reasonable relationship between licensee's pricing of licensed product and the health and safety needs of the public and that this relationship be supported by evidence'. Despite repeated requests by MSF and others, NIH has never enforced fair-pricing clause, nor has BMS honoured it. Thus, attempts by the Thai Public Health Ministry's AIDS division to negotiate the price of didanosine have been unsuccessful.

♦ **July 1992** — BMS files patent application for formulation of didanosine in Thailand, containing different antacid buffer to original preparation and with a specified dose range 'from about 5 to 100 mg per dosing unit' (similar to 5-150 mg formulation patents in other countries). Similar patent applications in USA in 1991 and 1992 rejected on the grounds of lack of novelty and inventive step, although new version of US patent finally granted in March 1999. Application made for a product patent two months before product patents recognised in Thailand

♦ **August 1997** — BMS files an amendment in which dose restriction omitted, thus seeking to expand scope of patent to all preparations, containing didanosine plus antacid buffer irrespective of dose

♦ **January 1998** — Thai Department of Intellectual Property grants amended patent. Amendment never published

♦ **April 1998** — Launch of generic didanosine 150 mg tablets by GPO planned. BMS threatens litigation and blocks production

♦ **October 2002** — Omission of dose range in patent amendment found to be unlawful by Thai Central Intellectual Property and International Trade Court. BMS appeals

♦ **January 2004** — BMS withdraws appeal; judgment upheld in favour of plaintiffs

Patents and access to medicines: What can be done

Martin Khor

The attempt by the global drug companies to prevent the South African government from providing cheaper medicines to its people brought to the fore the way international law has been used to undermine public health. The Third World Network, working with other public interest groups, has produced a manual containing guidelines that countries could use to maximise their rights within the TRIPS Agreement of the WTO, to provide affordable medicines and protect public health.

Access to medicines is a major public health issue, especially with the impact of patents on the prices of drugs. The Trade-Related Aspects of Intellectual Property Rights (TRIPS) Agreement in the World Trade Organisation in 1995 made it compulsory for WTO members to include medicines in their regime for product and process patents. (See Box)

A few years ago, there was a public outcry on how the monopoly granted by patents enabled the maintenance of excessive prices of medicines for HIV/AIDS. The cost of treatment with patented drugs per patient per year was US$10,000-15,000 in developed countries, whereas some generic producers in developing countries were able to provide them for as low as US$140. If developing countries are able to make or import these generic drugs at cheaper cost, that would significantly increase access to medicines.

Whilst mandating that WTO members have to allow patenting for medicines, the TRIPS Agreement does contain flexibilities. For example, if patented drugs cost too much, the government authorities can take measures such as issuing a compulsory licence to an agency or company to manufacture or import a cheaper generic version of that patented drug.

At the WTO's Ministerial Conference in 2001, the Doha Declaration on the TRIPS Agreement and Public Health was adopted. It reaffirmed and clarified the flexibilities available under the TRIPS Agreement, and proclaimed: 'We agree that the TRIPS Agreement does not and should not prevent Members from taking measures to protect public health....We affirm that the Agreement can and should be interpreted in a manner supportive of WTO Members' right to protect public health and in particular, to promote access to medicines for all.'

If the Doha Declaration is to be of benefit, the developing countries now have to establish appropriate provisions in their national patent legislation by using 'to the full' the flexibilities in the TRIPS Agreement. They also need national policies aimed at providing access to medicines for all.

The Manual

With this in view, the Third World Network (TWN) organised several meetings involving legal experts, NGOs and policy makers to discuss the options available to developing countries for policies and legal provisions that are oriented to meeting public health concerns (see following article). The outcome of these meetings was a *Manual on Good Practices in Public-Health-Sensitive Policy Measures and Patent Laws*, recently published by TWN.

The Manual contains three parts. Part I describes policy options to import, produce and export affordable medicines through measures that are consistent with the TRIPS Agreement. These include compulsory licensing, 'government use' procedures, and parallel importation of drugs that are patented in these countries, thus enabling the use of cheaper generic versions of the patented branded drugs, and also cheaper versions of the same branded products.

Part II provides model legal provisions for national patent laws that are sensitive to public health concerns, and consistent with the TRIPS Agreement. These are accompanied by explanatory notes that describe and explain the provisions, including how they comply with the TRIPS Agreement, with examples of 'good practices' in national laws from around the world.

Part III contains proposals for an appropriate institutional and administrative framework to implement the proposed patent laws and policy measures, including for compensation to the patent holder.

The Manual points to the following policy measures that can be taken.

Importing the drug

A country can import a generic version of the patented product by issuing a compulsory licence to a company or agency to import the drug, and the government has the freedom to determine the grounds upon which such licences are given. The imported drug can be from a country in which the drug is not patented, or in which the drug is patented (in which case the export-

ing country has also to issue a compulsory licence). The applicant has to firstly negotiate to obtain a voluntary licence from the patent holder, and if that fails, then a compulsory licence can be granted. Adequate compensation has to be paid to the patent holder.

A generic version of the patented drug can also be imported for 'public, non-commercial use' by the government. Under this 'government use' procedure, the prior consent of or negotiations with the patent holder are not required, but adequate compensation has to be paid. This method is suitable if the imported drug is to be used by the government.

There can also be 'parallel importation' of a patented product (i.e. not the generic version) from another country where the same patented product is being sold at a lower price than in the importing country. This is allowed under Article 6 of the TRIPS Agreement on exhaustion of rights, and the Doha Declaration reaffirms this. There is no need for an importer to obtain a compulsory licence, nor to pay compensation to the patent holder.

Local manufacture

If a drug is patented in a country, generic versions of the drug can be locally manufactured by a local company or agency that has been granted a compulsory licence. The applicant has to have negotiated with the patent holder for a voluntary licence and failed to obtain such a licence, before applying for a compulsory licence. This requirement, however, does not apply if the compulsory licence is issued on grounds of public non-commercial use, for national emergencies or situations of extreme urgency, or to remedy anti-competitive practices. Compensation has to be paid.

The government can also assign to a public or private agency the right to locally manufacture a patented product without the patent holder's permission, provided it is used for a public non-commercial purpose. Compensation has to be paid.

Export, including to countries with inadequate manufacturing capacity

A local producer of generic versions of patented products under a compulsory licence or government-use provision may export a portion of its output. However, Article 31(f) of the TRIPS Agreement requires that this production shall be 'predominantly for the supply of the domestic market' and thus there is a limit to the amount that can be exported. This restriction does not apply when the compulsory licence is granted to correct anti-competitive practices.

This restriction is a problem for developing countries with insufficient or no drug manufacturing capacities, as they may find it difficult to import the required medicines since there is a limit to the amount the potential exporting countries can supply to them.

The Doha Declaration asked the WTO to find an 'expeditious solution' to this problem. The WTO General Council in August 2003 adopted a decision on a 'temporary solution' in the form of an interim waiver to the Article 31(f) restriction, such that countries producing generic versions of patented products under compulsory licences would be allowed to export the products to eligible importing countries, without having to limit the exported amount.

However, the decision also obliges importing and exporting countries that wish to make use of the waiver to undertake several measures and fulfill several conditions, which are difficult to comply with.

The importing country has to notify the WTO by specifying the drug required, confirm it has insufficient or no manufacturing capacities, and take measures to prevent re-exportation of the products.

The generic manufacturer in the exporting country will require a compulsory licence. The exporting country has to notify the WTO of the grant of the compulsory licence and its conditions. The products must be labelled or marked through special packaging and shaping of the products.

The waiver is an 'interim solution' and a 'permanent solution' should be found by the middle of 2004, but it is unlikely this deadline can be met.

Other measures

The policy options have to be backed up with appropriate provisions in the national patent laws. The Manual provides model provisions for parallel importation, compulsory licensing and government use, as well as exceptions to patent rights, accompanied by detailed explanatory notes and examples of the relevant legal provisions in various countries.

Finally, the Manual has a section discussing the establishment and operation of an institution (or competent authority) to process compulsory licences.

It also examines how 'adequate remuneration' or compensation to the patent holder can be fixed. The experience of various countries is examined.

Conclusion

Patents do affect the access of patients to medicines. However, developing countries can take measures permitted by the TRIPS Agreement in pursuit of access to medicines for all.

They can study the policy options available to them, and introduce the appropriate laws and concrete measures. In the longer term, revisions to the TRIPS Agreement may also be desirable, in order that the existing flexibilities be expanded to meet the needs of patients and consumers. As millions of lives are at stake, both the shorter- and longer-term tasks are urgent.

Martin Khor is the Director of the Third World Network, which is involved in development and environment issues. The *Manual on Good Practices in Public-Health-Sensitive Policy Measures and Patent Laws* is available through TWN at *twnet@po.jaring.my*

Policy Measures to Facilitate Better Access to Medicines

POLICY MEASURE		REQUIREMENTS
IMPORTING THE DRUG		
Compulsory licensing	A country can import a generic version of the patented product by issuing a compulsory licence to a company or agency to import the drug, and the government has the freedom to determine the grounds upon which such licences are given. The imported drug can be from a country in which the drug is not patented, or in which the drug is patented (in which case the exporting country has also to issue a compulsory licence).	The applicant has to firstly negotiate to obtain a voluntary licence from the patent holder, and if that fails, then a compulsory licence can be granted. Adequate compensation has to be paid to the patent holder.
'Government use' procedure	A generic version of the patented drug can also be imported for 'public, non-commercial use' by the government. This method is suitable if the imported drug is to be used by the government.	Under this 'government use' procedure, the prior consent of or negotiations with the patent holder are not required, but adequate compensation has to be paid.
Parallel importation	There can also be 'parallel importation' of a patented product (i.e. not the generic version) from another country where the same patented product is being sold at a lower price than in the importing country. This is allowed under Article 6 of the TRIPS Agreement on exhaustion of rights, and the Doha Declaration affirms this by stating that each WTO member is 'free to establish its own regime for such exhaustion without challenge.'	There is no need for an importer to obtain a compulsory licence, nor to pay compensation to the patent holder.
LOCAL MANUFACTURE OF GENERICS		
Compulsory licensing	If a drug is patented in a country, generic versions of the drug can be locally manufactured by a local company or an agency (including government agency) that has been granted a compulsory licence by the government.	The applicant has to have negotiated with the patent holder for a voluntary licence and to have failed to obtain such a licence, before applying for a compulsory licence.This requirement however does not apply if the compulsory licence is issued on grounds of public non-commercial use, for national emergency or situations of extreme urgency, or to remedy anti-competitive practices. Compensation has also to be paid to the patent holder.
'Government use' procedure	The government can also assign to a public or private agency the right to locally manufacture a patented product without the patent holder's permission, provided it is used for a public non-commercial purpose.	Under the 'government use' procedure, the prior consent of or negotiations with the patent holder are not required. Compensation has to be paid.
EXPORT, INCLUDING TO COUNTRIES WITH INADEQUATE MANUFACTURING CAPACITY		
Exporting products that have been produced under compulsory licensing or a 'government use' procedure	A local producer of generic versions of patented products under a compulsory licence or government-use provision may export a portion of its output. However, Article 31(f) of the TRIPS Agreement requires that this production shall be 'predominantly for the supply of the domestic market' and thus there is a limit to the amount that can be exported. This limitation may cause supply to be restricted to countries with inadequate manufacturing capcity of their own. Recognising this problem, the WTO in August 2003 decided to give an interim waiver to an exporting country from having to adhere to this Article 31(f) restriction, if it is exporting to countries with no or inadequate manufacturing capacity.	The Article 31(f) restriction does not apply when the compulsory licence is granted to correct anti-competitive practices. Adequate compensation should be paid. To obtain the waiver, several conditions must be met. The importing country has to notify the WTO of the quantities of the drug required, confirm it has insufficient or no manufacturing capacities and that it intends to grant a compulsory licence. It also has to prevent re-exportation of the products. The generic manufacturer in the exporting country will require a compulsory licence. The exporting country has to notify the WTO of the grant of the compulsory licence and its conditions, the quantities for which it has been

granted, and the importing countries. Only the amount needed by the importing country may be manufactured under the licence, and all of this output must be exported to the importing country. The products must be clearly labelled or marked through special packaging and shaping of the products, provided it does not significantly impact on price. And adequate compensation should be paid.

* Adapted from the *Manual on Good Practices in Public-Health-Sensitive Policy Measures and Patent Laws*. available through TWN at *twnet@po.jaring.my* and at *www.twnside.org.sg*.

128 pages. 14.5 cm X 21.5 cm
US$9.00 (Third World)
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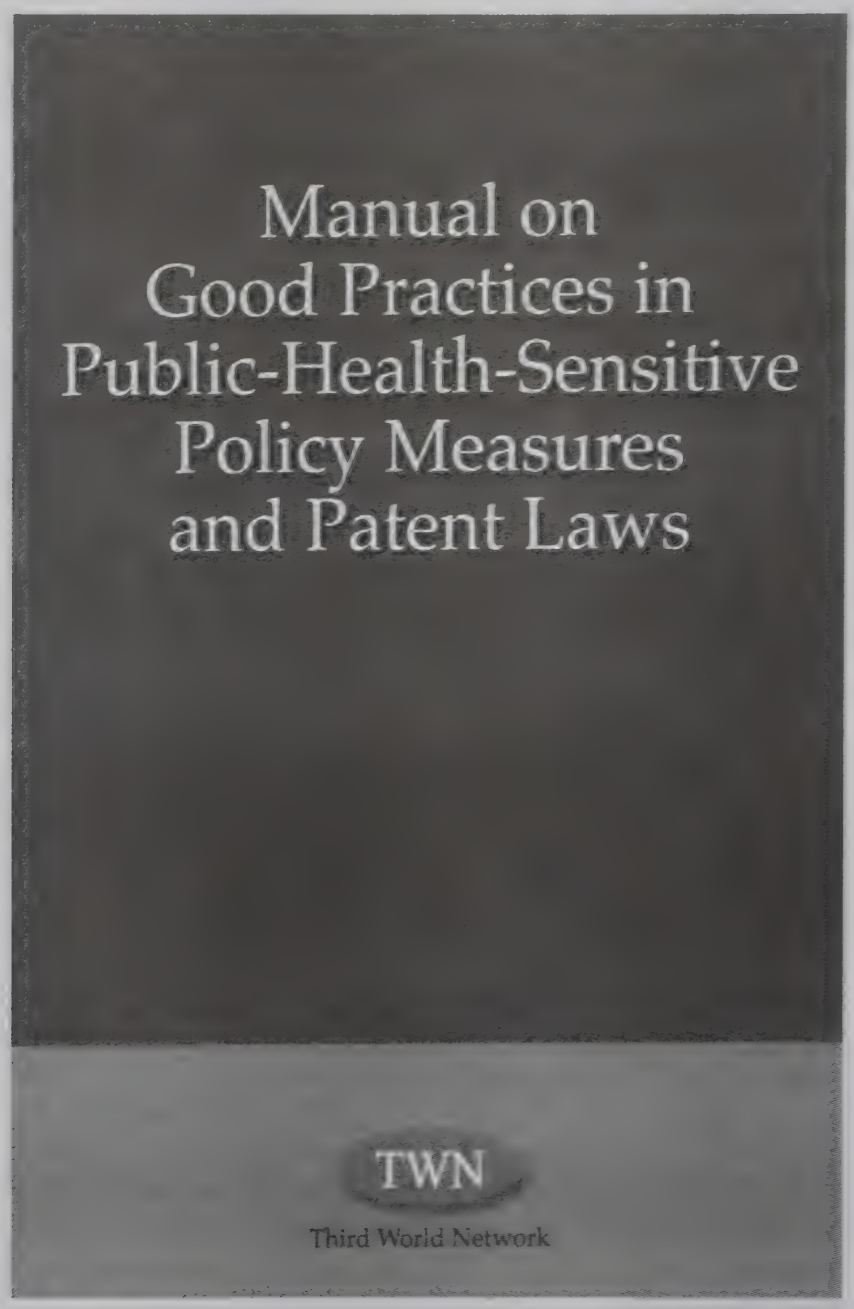
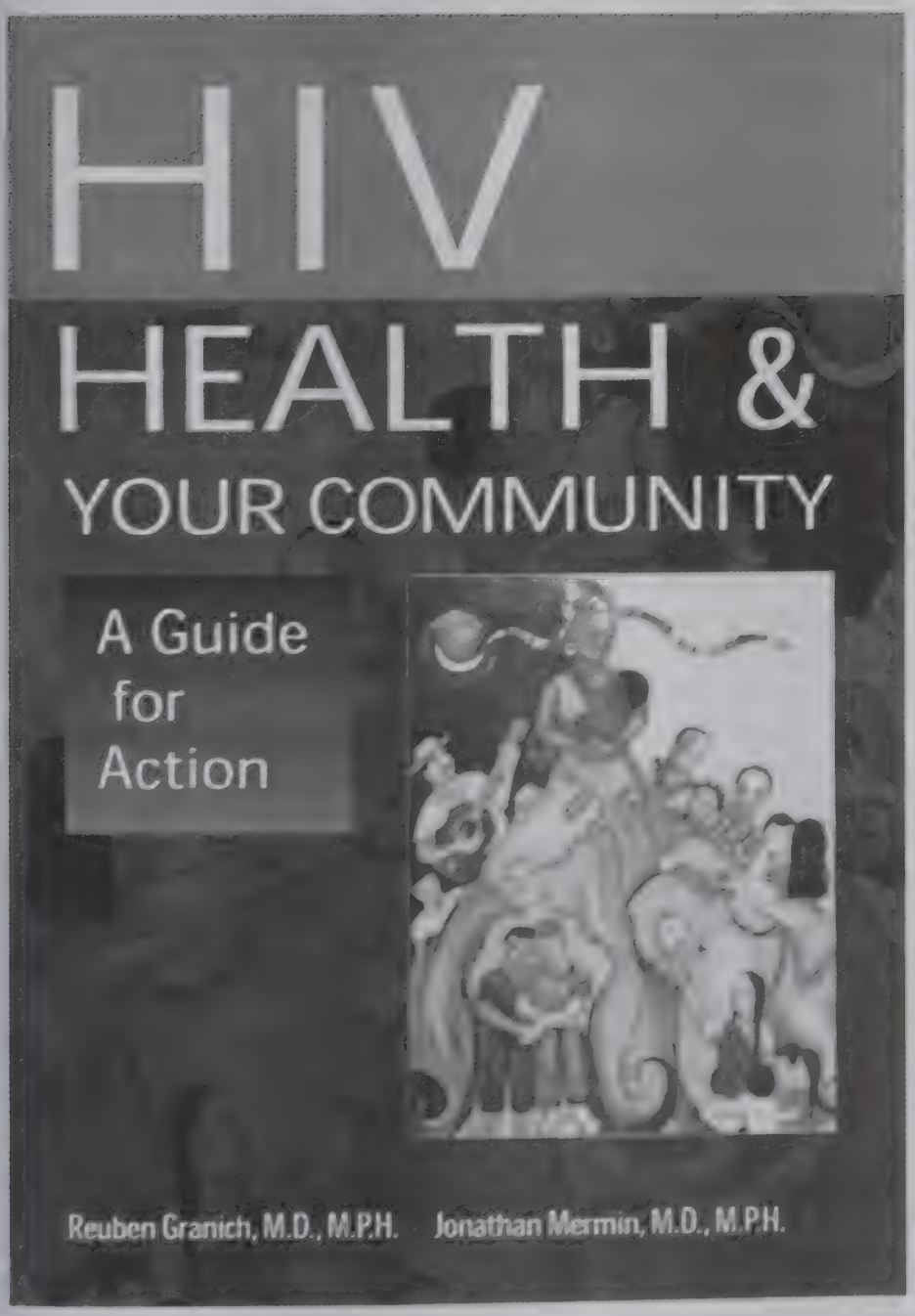




HIV, Health and Your Community is a thorough, easy-to-understand guide for health workers throughout the world. Written by Drs. Reuben Granich and Jonathan Mermin of the Center for Disease Control, the book was designed as a manual for people confronting the HIV/AIDS pandemic in their communities. This manual is easily accessible to those with little medical or technical knowledge, and can provide life-saving information to people without prior training in HIV prevention and care for those living with AIDS.

You can access and download this resource by visiting Hesperian's website at *http://www.hesperian.org/buy_htm#HIV* then following the link to the pdf file.

Publisher: the Hesperian Foundation
256 pages, $16.00

Public health versus international treaty

An experience with the issue of TRIPS and access to medicines

Third World Network—People's Health Movement

The following article traces the background of the campaign among public interest groups that led to the Doha Declaration on the TRIPS Agreement and Public Health in November 2001 and to the publication of a manual on public-health-oriented policy measures and patent laws.

The issue of high drug prices was brought to public attention by effective campaigning by Medecins Sans Frontieres (MSF) , Consumer Project on Technology (CPT) and health groups especially AIDS-related patients' groups in the US, South Africa and Brazil. Development groups like Oxfam and TWN also began bringing up the issue. A significant event in fostering a common NGO front was an Oxfam workshop in Brussels in March 2001 on the TRIPS Agreement, which TWN attended together with other NGOs, experts, diplomats, etc. By this time the scandal of patents and high drug prices had been reported in the mass media. Thus there was a climate for furthering the campaign involving NGOs, the media and activists, etc.

At the Brussels meeting, Pascal Lamy (EC Trade Commissioner), when challenged by NGOs on the issue, said that it was not up to the EC to demand a change in TRIPS, it was up to the developing countries to do so. He said that if they did so, the EC would respond. After the Brussels meeting, TWN brought the message to the attention of some African and other delegations in Geneva, i.e. that the developing countries should take the lead inside the WTO to ask for changes in TRIPS, or at least to make it more difficult for rich countries' governments (like the US) to bully poor countries from exercising their rights to use the flexibilities available to them in TRIPS, such as compulsory licensing. TWN, like other groups, encouraged Southern countries to take action on this issue inside the WTO.

Partly inspired by the NGO campaigns and media publicity on the issue, several developing countries, including the Africa Group, Brazil and India, developed a coalition that involved over 70 Southern countries to demand:

1) That countries be allowed to exercise their right within TRIPS without being politically and legally pressured and bullied by rich countries especially the US, or by big drug companies.

2) That eventually countries be allowed to realise the right to access to medicines by appropriately amending TRIPS.

TWN worked closely with MSF, CPT and Oxfam which together issued joint statements and held press briefings. TWN also worked with Southern delegations when they were formulating their positions and statements in the WTO's TRIPS Council. At the same time NGOs and health groups especially HIV-AIDS patients' groups also intensified the campaigns in the North and succeeded in having pressure put on the Northern governments to respond to the demands being made by the Southern governments inside the WTO. The actions of health groups to assist Brazil in countering the case brought by the US against it in the WTO, and to assist South Africa in the court case brought against it by drug companies, were part of the overall campaign. NGOs also developed contact with some generic producers. In the meanwhile, the positive positions taken by WHO on the issue of patents and drugs also provided valuable intellectual and moral support to the movement of governments and NGOs.

The coalition of Southern governments with the NGOs and health groups of the South and the North, and with WHO in the background, was a major force that pushed towards the Doha Declaration on the TRIPS Agreement and Public Health in November 2001. The Declaration did not really legally expand the rights of WTO members to offset patents on medicines. But it was very significant nevertheless in politically reaffirming and clarifying the extent and the range of members' rights under TRIPS to make use of instruments such as compulsory licences, parallel imports and government use to counterbalance the monopoly rights given to patent holders. It also affirmed the principle that TRIPS should not prevent the implementation of public health measures.

The existence of the Doha Declaration and the process leading to it (especially the public awareness and activism that had been aroused) resulted in a political situation which has made it more difficult for developed countries to take up a case against Third World countries for exercising their right to compulsory licences etc. Thus there was an expansion of political space for developing countries, NGOs and health groups to take measures to offset patent monopoly powers of drug companies. Governments that want to exercise their rights need not be looked upon as extreme radicals or as pirates stealing company patents. They are merely exercising their right and duty to provide more affordable medicines.

Moreover, Paragraph 6 of the Doha Declaration held out the prospect that one element in TRIPS could be amended or waived, i.e. the restriction in Article 31 (f) that supply under compulsory licences should be predominantly for the domestic market. This restricts the amount for exports. This clause discourages generic production (due to limits placed on economies of scale) and prevents poor countries from importing as the supply of generics from potential exporting countries is restricted. The fight to

obtain a solution to this Para 6 problem continued after the WTO Doha Ministerial Conference of November 2001.

After Doha, a new round of activities began among NGOs. TWN was encouraged by some governments and experts to focus at the national level. Whilst TRIPS poses a problem at the level of international law, many countries are also not making adequate use of the flexibilities available to them at the national level. TWN thus saw it as a priority to assist policy makers (as well as NGOs) to formulate appropriate laws and policies at the national level that can best enable governments to implement measures favourable to public health.

TWN established an expert group to formulate guidelines for appropriate national laws and policies that maximise the exercise of public-health-oriented measures and which are at the same time consistent with the obligations under TRIPS. The group included international law experts, some diplomats and government experts, representatives from MSF, CPT, Health Action International (HAI), TWN, etc. It met three times in 2002 and 2003. The expert group produced a *Manual on Good Practices in Public-Health-Sensitive Policy Measures and Patent Laws*. Various drafts were developed in 2002 and 2003. The Manual sets out the range of policies available to governments, including compulsory licences, parallel importing and government use, for importing, producing or exporting drugs, including generic versions of drugs that have been granted patents in the country taking the measures. The Manual points out the pros and cons of choosing each of the various options. It provides model legislation, usually drawn from existing laws or legal provisions in various countries (including developed countries), which would have to be in place in order to enable the implementation of the policies and measures. The suggested legal provisions are TRIPS-compliant.

The Manual drew from some of the best expertise available from the world of NGOs, legal experts and government experts. Its aim is to provide governments with guidelines and tools with which to maximise their rights to provide affordable medicines in implementing the Doha Declaration. The ultimate aim of course is to maximise the rights of patients to affordable medicines.

TWN and Health Action International Asia-Pacific (HAI AP) with the support of WHO organised a regional workshop in Colombo in April 2003, to discuss national policies in relation to TRIPS and public health. The Manual was presented and discussed at the meeting, which was attended by senior health and patent officials as well as health groups from 18 Asian countries. Resource persons were drawn from experts including from CPT, MSF, HAI, TWN, WHO, etc. The workshop's aim was to enable policy makers to get the best expert advice on the best options among measures they can take, and still be TRIPS-compliant. It succeeded in raising awareness among policy makers in the region as to how they should proceed, especially in light of the Doha Declaration.

Although measures like compulsory licences have been available, few, if any, developing countries have issued such licences because the policy makers are either not clear as to what options are available to them, or are afraid of retaliation in one way or another by developed countries. Some confusion and fear remain despite the Doha Declaration. The Manual and the Colombo seminar were among the ways that TWN sought to provide clarity, expertise and courage to the policy makers.

The challenge is for each country to adopt the most appropriate legal provisions, policies, measures and practices, from the perspective of public health. The Colombo meeting invited both health and patent officials to be present. At the meeting, government officials explained the content and status of their national laws and policies and compared these with those of other countries present as well as with the Manual.

At the final session the meeting presented a set of conclusions and recommendations to the Health Minister of Sri Lanka in the presence also of the WHO regional representative.

Among the recommendations were that:

♦ Each country should adopt national laws to maximise the use of TRIPS flexibilities to protect and promote the health of its citizens and to provide affordable medicines for all.

♦ A strengthened system of information sharing, communications and research should be established. Policy makers, NGOs, social movements, professionals, experts and generic drug producers should be part of this system. The organisers of the workshop (HAI AP, TWN, WHO) should discuss among themselves how to follow up on this proposal.

♦ Generic drug producers should strive to strengthen their activities, to remain viable and to develop further. They should form an association or network among themselves to coordinate activities and urge policy makers to adopt appropriate measures to facilitate use and production of generics. They should also try their best to transfer technology and production know-how to all countries in the region.

♦ Governments in the region should establish cooperation activities among themselves, not only to share information and best practices, but also to establish among themselves cooperation arrangements for production, technology-sharing, distribution, import and export of compulsory licenses and other measures.

♦ WHO has an important role to play in bringing policy makers together to implement national and regional activities. The planned WHO activities in the region, such as Ministerial Conferences, should include sessions on patents and medicines where experts and NGOs should also be invited to present their views.

TWN is seeking to hold similar workshops on national implementation in other regions. Other groups such as CPT and MSF have been actively helping some governments to embark on measures to obtain affordable medicines. Together some of the groups have agreed to cooperate with one another to provide a pool of expertise and human resources to assist and advise governments that want to take the appropriate measures. The assistance of international agencies especially WHO will also be crucial.

In 2002 and 2003 the WTO members were pre-occupied in finding a solution to the Para 6 problem of overcoming the restriction that compulsory licensees should produce predominantly for the domestic market. Eventually a decision was adopted in the WTO in August 2003, which allowed

members to waive this restriction with regard to medicines, but several conditions were placed on countries wanting to do so. These conditions make it difficult for countries or generic producers to comply. Despite the obstacles, we believe that governments that are determined to produce, import or export medecines can do so at prices that are significantly more affordable than the levels set by patent holders. TWN intends to update the Manual to take into account the Para 6 developments.

Despite all these attempts to have public health measures and still be TRIPS-compliant, we recognise that TRIPS itself remains a big millstone. It must be substantially amended, for example to allow countries to exempt medicines from patentability, as was the case before TRIPS. TRIPS itself should not remain within the WTO, which is a trade organisation. It should be a standalone treaty and not be part of a 'single undertaking' together with other agreements in the WTO. Countries should be entitled to choose whether to join or not join the treaty. The treaty itself should be revised to fully take the public interest into account. What has been done by the Southern governments and the NGOs so far has been an attempt at damage control and limitation. This attempt should now be extended towards real substantive change in international law.

The experience described shows that it is vital for Northern and Southern NGOs and health rights groups to work together, and that such coalitions can be effective if there is commitment, expertise and effort. They can work together with willing governments and policy makers, as well as official international agencies. When they encounter a clash between the realisation of the human right to health, and imbalanced and unfair international treaties like TRIPS, or internationally imposed loan and aid conditionalities as in the structural adjustment programmes, it is possible for this public health coalition to push for public health to be placed before profits, and to raise awareness worldwide. It may take a little more time to change the treaties or to create new and better ones. But if we keep on at it, even that may come about. We look forward to working with MSF and others to hasten the coming of that day.

The struggle for cheap drugs and the right to health

Consumers' Association of Penang

The Doha Declaration on the TRIPS Agreement and Public Health in 2001 was significant because it reaffirmed and clarified the rights of countries to use measures under TRIPS like compulsory licensing and parallel imports to restrict the monopoly rights of patent holders in the interest of the public good.

Earlier, when Third World countries like those in Africa had tried to use the provisions in TRIPS to protect public health, they were challenged and pressured not to do so.

The public outrage and bad press that drug companies received and the international activism and awareness this aroused provided the background to Doha.

The experiences of Africa, Brazil and Thailand which tried to provide cheap anti-HIV/AIDS drugs to their people are summarised below.

Brazil bullied for developing low-cost anti-AIDS drugs

The mounting costs of patented anti-AIDS drugs forced Brazil to produce generic copies to treat HIV/AIDS sufferers.

Brazil's aid programme has helped contain the spread of HIV. Some 540,000 people were infected in 2000. This is half the number projected by WHO six years ago. The incidence of TB in HIV patients has fallen by half as well. The decline in hospitalisation from opportunistic infections from 1997 to 1999 saved the Health Ministry US$422 million.

In May 2000 the office of the US Trade Representative (USTR) put Brazil on the Special 301 Priority Watch List, a first step towards unilateral trade sanctions. Early in 2001, the US filed a complaint against Brazil in the WTO for not complying with TRIPS.

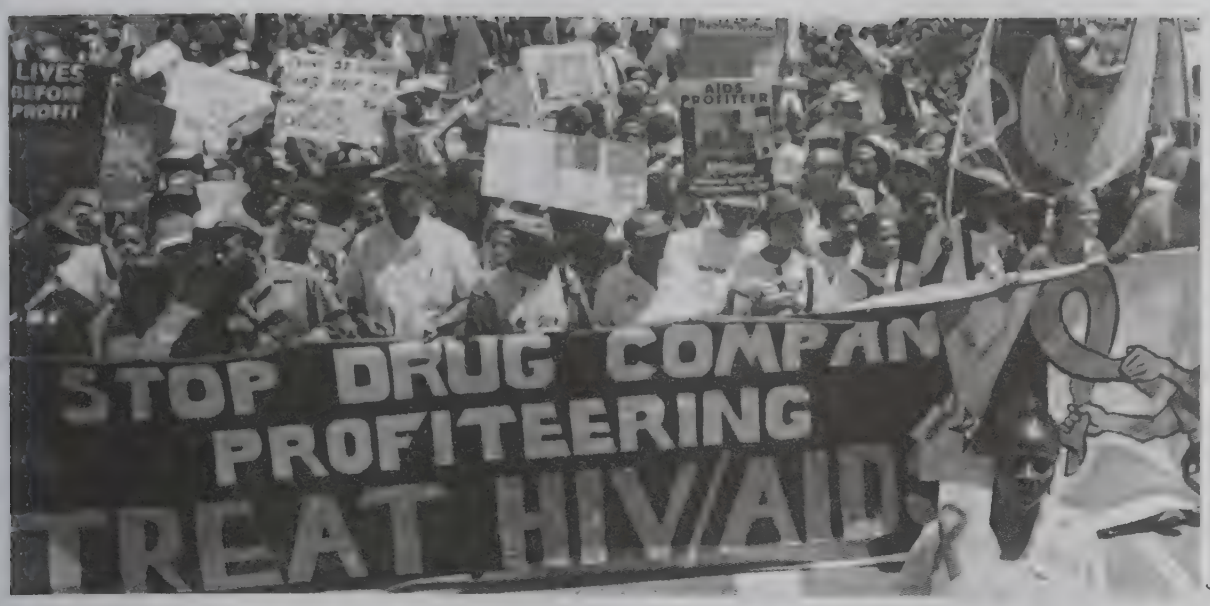
Just like South Africa, Brazil's crime was to invoke 'national emergency provisions' in its patent laws to make low-cost generic versions of anti-AIDS medicines. Because of this, 90,000 HIV-affected people are receiving FREE treatment.

Since it started to produce its own anti-AIDS drugs, the prices have all dropped. The price of patented drugs with no Brazilian generic equivalent fell by 9% from 1996 to 2000; while the price of those that compete with generics from Brazil plunged 79%.

Brazil says it has saved almost US$500 million in anti-AIDS medicines due to local production. The annual cost of triple therapy treatment in Brazil is around US$4,000 compared to US$15,000 in the US. If Brazil were to spend the same amount on imported drugs, it would have eaten up the entire national drugs budget.

Brazil's intellectual property law of 1996 requires the patent holder to make the product in Brazil. If this does not happen, the government can issue a compulsory licence to another producer, unless the patent holder can show that local production is not feasible. The law also states that all drugs registered before 15 May 1997 are now public property.

This allows Brazil to make all the first-generation anti-AIDS drugs



Africa Recovery

Under patents, drug companies have the monopoly to charge skyrocketing prices for HIV/AIDS medicines, putting them beyond the reach of the majority in the Third World.

like AZT, DDI, D4T and 3TC. It covers nevirapine and indinavir (which makes up the third drug in the triple cocktail). Brazil's state laboratories now make all but four of the 12 anti-AIDS drugs.

Unfazed by the US-WTO threat, Brazil announced local production of generic versions of two anti-AIDS drugs if the companies producing them refuse to lower their prices by June.

The two drugs are efavirenz, made by Merck and sold under the trade name STOCRIN, and nelfinavir, which is sold as VIRACEPT by Hoffman La Roche and Pfizer. The wholesale prices per course of treatment for one year for VIRACEPT and STOCRIN are US$7,100 and US$4,800 respectively. Brazil says it would cost less than half the current price if Brazil were to make them.

Brazil has shown the rest of the world that its AIDS programme (and the availability of cheap generic anti-AIDS medicines) works. It has become a model for other countries by standing up to the big US bully boys.

Thailand should not even collect data on medicine costs

Thailand has a million HIV victims out of a total population of 61 million. Since 1993, the Thai government had supplied the HIV antiviral zidovidine, which resulted in a drastic drop in price from US$324 in 1992 to US$87 in 1995.

Meanwhile, under threat that the US would limit its textile imports, Thailand passed a law on product patent protection in 1992. As a safeguard however, the Thai authorities created the Pharmaceutical Patent Review Board (PPRB) to collect economic data including the production cost of medicines. This move was not viewed favourably by the US either.

Trade pressure was again applied on Thailand when the latter attempted to produce generic didanosine (DDI). This drug, which is used in triple combination therapy for HIV, was developed by the US National Institutes of Health with taxpayers' money and patented as DDI. The US government gave the exclusive licence to Bristol-Myers Squibb (BMS) to make and market DDI in return for a royalty of 5-6% of net sales. BMS is the sole supplier of the drug in Thailand and sells it (VIDEX) at a monthly cost of US$136.

Thailand wanted to produce the drug, thus enabling AIDS patients to receive one low-tech double therapy combination (AZT/DDI) at an affordable price. However, Thailand was blocked from doing so when BMS obtained a patent on antacids buffer used to pack VIDEX into pill form. BMS also prevented the producers of the raw materials for DDI from selling it to the Thais, according to a *New York Times Magazine* report. Thailand was prevented from making D4T and 3TC when BMS and Glaxo (whose patented versions of the drugs are ZERIT and EPIVIR respectively) took advantage of 'market exclusivity' to retain their monopoly in Thailand. The latter was able to make generic D4T and 3TC recently. Since July 1997 as a result of the financial crisis, the daily minimum wage in Thailand had stagnated at US$4.50.

In 1998, threatened with increased tariffs on imports of wood products and jewellery by the US, Thailand dropped the DDI plan. The threat came at a time when the Thai economy was crippled by the Asian economic crisis. Under the urging of US trade officials, Thailand disbanded the PPRB and enacted a law to restrict its rights to issue compulsory licences for medicines. This law, ironically, is more restrictive than the rules set out in the TRIPS Agreement.

The USTR wanted Thailand to tighten its patent laws even further and withdraw its drug procurement policies which favour the local industry. The Pharmaceutical Research and Manufacturers of America (PhRMA) has also attacked Thailand's parallel imports of generics on WHO's Essential Drugs List.

South Africa told to change its Medicines Act

South Africa was threatened with US trade sanctions unless the nation amended its Medicines and Related Substances Control Amendment Act 1997. This law would enable South Africa to seek the cheapest world price for a drug through parallel importing; and to grant rights to make copies of patented drugs without the approval of the patent holder by imposing compulsory drugs licensing. This law would make life-saving medicines affordable to South Africans. Under compulsory licensing South Africa can reduce the price of drugs by as much as 90%.

South Africa has the world's fastest-growing HIV infection rates. Some 16% of the population, 20% of pregnant women, and 45% of the armed forces test HIV-positive and black people have the highest risk of dying early from AIDS.

An estimated one million people have already died. The standard multidrug AIDS therapy that cost more than US$12,000 a year is out of reach of almost all South Africans, whose average

annual income is less than US$3,000.

The reaction to South Africa's new law came first from the 41 pharmaceutical companies which jointly filed a suit in the Pretoria High Court barring the law from taking effect, claiming that it violated intellectual property rights and was thus unconstitutional.

By 1998, the drug companies had brought their campaign against South Africa to the White House. In October 1998, the US Congress cut off foreign aid to South Africa in an effort to force its hand.

The US Trade Representative Charlene Barshefsky denied South Africa tariff breaks on exports to the US worth more than US$3 billion in 1998 and placed it on its 'watch list' for unfair trade practices. Pressure was brought to bear on Pretoria by the Commerce Secretary, the US Embassy and the Clinton administration.

In a report dated 5 February 1999, to Congress from the US Trade Representative: 'All relevant agencies of the US government have been engaged in an assiduous concerted campaign' to get South Africa to capitulate.

Even the European Commission lent its weight to the US attack: Sir Leon Brittan, the Trade Commissioner at the time, issued a warning to South Africa's Vice President in a letter in March 1998, that Pretoria's drug law was 'at variance with South Africa's obligations under the WTO and its implementation would negatively affect the interests of the European pharmaceutical industry'.

All these measures were taken by the US to prevent South Africa from exercising its rights under TRIPS.

The US charge that South Africa was violating WTO rules was strongly condemned by AIDS activists, health and consumer groups, which accused the Clinton-Gore administration of practising double standards and hypocrisy.

However, thanks to protests by US AIDS campaigners, the sanctions threat against South Africa was finally dropped. In April 2001, the suit against the South African government was withdrawn.

— *Utusan Konsumer* magazine (Consumers' Association of Penang, Malaysia)

AIDS and the medicalisation of poverty

Charles Geshekter

Primary health care systems in Africa will remain hampered until public health planners systematically gather statistics on morbidity and mortality to accurately show what causes sickness and death in specific African countries.

During the past 13 years, as the external financing of HIV-based AIDS programmes in Africa dramatically increased, money for studying other health sectors remained static, even though deaths from malaria, tuberculosis, neonatal tetanus, respiratory diseases and diarrhoea grew at alarming rates.

While western health leaders fixate on HIV, approximately 52% of sub-Saharan Africans do not have access to safe water, 62% have no proper sanitation, almost half live on less than one dollar a day, and an estimated 50 million pre-school children suffer from protein-energy malnutrition.

Poor harvests, rural poverty, migratory labour-systems, urban crowding, ecological degradation, social mayhem, the collapse of state structures, and the sadistic violence of civil wars are the primary threats to African lives. When essential services for water, power, and transport break down, public sanitation deteriorates and the risks of cholera, tuberculosis, dysentery, and respiratory infection increase.

Historian Randall Packard documented the attempts by the South African government to control the spread of tuberculosis and to lower tuberculosis morbidity and mortality rates. Even though tuberculosis is curable and the available control measures are sufficient to combat it effectively with antitubercular drugs, the apartheid government made little impact on the overall prevalence of the disease.

Packard showed that the South African government was unwilling 'to address the foundations of black poverty, malnutrition, and disease upon which the current [1980s] epidemic of tuberculosis is based ... [and] placed their faith in the ability of medical science to solve health problems in the face of adverse social and economic conditions.'

Poverty indicators

By the mid-1990s, AIDS researchers and policy makers confused correlation with causation as they conflated tuberculosis incidence and the reactivation of dormant TB with HIV antibody status. This comingling enabled conventional AIDS programmes to link efforts to reduce the infectiousness and severity of tuberculosis with family planning, safe sex messages and behaviour modification proposals.

In August 1998, the *New York Times* reported that Zimbabwe had become 'the center of the world's AIDS epidemic.' It claimed that as many as 25% of all adult Zimbabweans may be infected with HIV, the highest infection rate on earth. Although it provided no figures for previous years, the article acknowledged that the presumed increase in HIV incidence had occurred when increasing poverty, food shortages and instability had 'begun to overcome the country. Tuberculosis, hepatitis, malaria, measles and cholera ... have surged mercilessly. So have infant mortality, stillbirths and sexually transmitted diseases.' Malarial deaths had risen from 100 in 1989 to 2,800 in

Africa Recovery

Poverty or the agony of a virus?

1997 and tuberculosis cases jumped from 5,000 in 1986 to 35,000 in 1997. The reporter admitted these diseases were all indicative of deepening poverty, calling TB 'the sentinel illness of poverty and social decline.'

Other articles in the macabre series, entitled 'Dead Zones,' illustrate a fundamental flaw in the HIV/AIDS model. Among sick or dying Africans, clinicians cannot distinguish who would test antibody-positive even if test kits were available. AIDS diagnoses are made presumptively. People are diagnosed as having AIDS simply by having the conditions that HIV is said to cause, such as tuberculosis or the symptoms of malaria (persistent night sweats, fever, wasting) or those of cholera (diarrhoea, fever, wasting).

Former WHO Director General Hiroshi Nakajima warned emphatically that 'poverty is the world's deadliest disease.' Indeed, the leading causes of immunodeficiency and the best predictors for clinical AIDS symptoms in Africa are impoverished living conditions, economic deprivation and protein malnutrition, not extraordinary sexual behaviour or the trace measurements of antibodies for a mysterious virus that has proved difficult or impossible to isolate directly, even from AIDS patients.

The so-called 'AIDS epidemic' in Africa is being used to justify the medicalisation of sub-Saharan poverty.

Rather than treat the clinical symptoms of AIDS as the manifestations of impoverished living conditions, researchers like Dr. David Alnwick, UNICEF's health chief, invert the cause-and-effect relationship to allege that 'all our efforts at providing safe water and other protections for children have been undermined, undone, by the AIDS epidemic.'

Thus, Western medical intervention takes the form of vaccine trials, drug testing, and evangelistic demands for behaviour modification by safe sex missionaries.

In 1997, the Division of AIDS at the US National Institute of Allergy and Infectious Diseases concluded that there was 'not enough evidence that a live attenuated HIV-1 vaccine [was] safe – or effective.'

Nonetheless, the International Association of Physicians in AIDS Care (IAPAC) insisted that it was wrong to require a vaccine to meet US safety and efficacy standards because the alleged number of AIDS cases rendered 'further delay unethical.' According to the International AIDS Vaccine Initiative, '$500 million in vaccine research is needed to encourage drug companies to move toward the eventual goal of profiting from AIDS vaccines, not just drugs to treat the epidemic.'

When a United Nations panel termed American medical and testing standards a form of 'cultural imperialism' that should not be imposed on African countries, Dr. Peter Piot (head of the UNAIDS Programme), in an astonishing reversal, endorsed the recommendation which he welcomed as a 'shift from older attitudes of paternalism and protectiveness to greater empowerment by developing countries.'

Cure poverty to cure AIDS

AIDS scientists and public health planners should recognise the role of malnutrition, poor sanitation, anaemia, and parasitic and endemic infections in producing the clinical AIDS symptoms that are manifestations of non-HIV results.

The data strongly suggest that socio-economic development, not sexual restraint, is the key to improving the health of Africans. Wherever one projects high rates of HIV antibodies in Africans, one also finds high rates for all germs indicative of sanitation problems, which in turn indicate abject poverty, destitution and a high disease burden, rather than HIV run amok.

Phillipe and Evelyn Krynen, medically trained charity workers employed by the French group Partage in Kagera Province (Tanzania), report that when 'appropriate treatment was given to villagers who became ill with complaints such as pneumonia and fungal infections that might have contributed to an AIDS diagnosis, they usually recovered.'

A similar observation came from Father Angelo D'Agostino, a former surgeon who founded Nyumbani, a hospice for abandoned and orphaned HIV-positive children in Kenya: 'People think a positive test means no hope, so the children are relegated to the back wards of hospitals which have no resources and they die. They are very sick when they come to us. Usually they are depressed, withdrawn, and silent .... But as a result of their care here, they put on weight, recover from their infections, and thrive. Hygiene is excellent [and] nutrition is very good; they get vitamin supplements, cod liver oil, greens every day, plenty of protein. They are really flourishing'.

And a 1998 study of pregnant, HIV-positive women in Tanzania showed that simply providing them with inexpensive micronutrient supplements produced beneficial effects and decreased adverse pregnancy outcomes.

The researchers found that women who received prenatal multivitamins had heavier placentas, gave birth to healthier babies and showed a noticeable 'improvement in fetal nutritional status, enhancement of fetal immunity, and decreased risk of infections.'

Their commitment to the belief that AIDS was caused by a viral infection, obliged the researchers to conclude that 'how the individual vitamins produce these effects is not fully understood.' — *African Agenda* (Ghana).

AIDS groups protest US efforts to block generics

Jim Lobe

US Africa and AIDS activists are increasing pressure on the administration of President George W. Bush to abandon its apparent efforts to block the use of US aid to purchase life-preserving generic anti-AIDS drugs for needy Africans, about 6,000 of whom die every day from the disease.

On 29 March, nine AIDS activists were arrested by police in Washington DC after chaining themselves together and blocking traffic in front of the downtown headquarters of the main lobbying association for the US pharmaceutical companies that are behind the administration's efforts.

The Pharmaceutical Research and Manufacturers of America (PhRMA) has been pressing the administration to oppose the use of generic drugs by the US Agency for International Development (USAID) and other international donors in favour of brand-name drugs that are generally more expensive.

The demonstrators were trying to draw attention to a US-backed meeting in Botswana at which Washington was trying to gain an 'international consensus' from United Nations agencies and African countries on what criteria should be applied to determine the safety and quality of antiretroviral drugs that are bought by USAID and other donor agencies.

'The US initiated the Botswana conference at the behest of the pharmaceutical companies, and its agenda is to protect their profits by blocking the procurement of generic AIDS drugs,' said Salih Booker, head of Africa Action, one of the co-sponsors of the 29 March protest.

'If the US succeeds, millions of people living with HIV/AIDS will be left without the medicines they need to survive.'

The Botswana meeting came amid growing concern over the fate of the global anti-AIDS fight, which appears to have stalled in recent months due to the failure of major donors to commit more money to the effort and because of continuing wrangles over the use of patented or generic drugs.

Activists had hoped that a proposal made by Bush himself 14 months ago to allocate $15 billion over five years to fighting AIDS in Africa and the Caribbean would inject major momentum to global anti-AIDS efforts.

But the Bush administration's opposition to the use of generic drugs and its insistence on providing the vast majority of the money through bilateral channels rather than through the multilateral Global Fund to Fight AIDS, Tuberculosis and Malaria, have contributed to the sense that the international response to the worst epidemic in recorded history is falling far short of what is required.

Indeed, the lead article in the 28 March *New York Times*, the US' most influential newspaper, was headlined 'Plan to Battle AIDS Worldwide is Falling Short'. The feature article noted prominently that only about 300,000 people in the world's poorest nations are currently getting live-preserving antiretroviral drugs, out of the approximately 6 million who need them.

Late last year, the World Health Organisation (WHO) launched its '3 by 5 initiative' to have 3 million people receiving the drugs by 2005. But in March, Stephen Lewis, the special UN envoy for AIDS in Africa, the worst-affected region, admitted that the paucity of donor contributions to date would make it impossible to reach that goal.

In that respect, the battle over generics versus brand-name drugs is critical. Even though major western manufacturers have slashed the prices they charge for these drugs in the world's poorest countries, they remain more expensive than generics.

US officials are particularly opposed to the use of fixed-dose combinations (FDCs) of anti-retroviral drugs, which combine drugs from multiple sources into single pills that are taken twice daily and that are currently recommended for use by WHO. (see box story)

The generic versions of these drugs cost as little as $140 per person per year, while the same combination from brand-name companies is priced at a minimum of $560 per year and must be taken in the form of six pills a day.

According to the activists, Washington had hoped to persuade participants at the Botswana meeting to reject FDCs on the grounds that they do not meet adequate safety and quality standards. US officials deny that was the purpose of the meeting and stress that they have never ruled out using generics, even for the administration's own President's Emergency Plan for AIDS Relief (PEPFAR), Bush's five-year programme.

But the activists say Washington's denial is disingenuous, particularly in light of WHO's pre-existing approval of FDCs.

'The moves by the US to call into question the safety and efficacy of generic AIDS drugs represent a callous attempt to undermine the WHO's existing rigorous international standards,' said Booker. 'The

administration is now essentially attacking the WHO's "3 by 5" initiative because it knows that generic FDCs are indispensable to achieving that goal'.

'President Bush is a drug company puppet,' said Asia Russell of Health Global Access Project (Health GAP). 'He plans to force millions of people with HIV/AIDS to accept higher pill burdens and waste tax money to create a slush fund for Big Pharma. If Bush would use the WHO's quality-assured generics, we could treat four times as many people in need'.

The activists are not without powerful allies.

Oposition Democratic Senator Edward Kennedy and his Republican colleague, John McCain, sent a letter to the White House asking that Bush accept WHO-approved generics.

'We should wait no longer to provide safe and effective low-cost medications to the developing world, and again, urge you to reconsider the administration's actions,' they wrote. 'Make no mistake, delays will cost lives'.

Moreover, the European Union's (EU) drug regulatory authority pulled out of the Botswana meeting, which could make the 'international consensus' sought by Washington much more difficult to achieve.

Fuelling the fire is the fact that Bush's new global AIDS tsar, Randall Tobias, is himself a former chief executive officer at the US drug company, Eli Lilly. While he has repeatedly insisted that Washington will support any drug deemed safe and effective at the lowest possible price, he has also raised questions about the reliability of generics.

Tobias's past ties to the pharmaceutical companies, which were big donors to Bush's 2000 election campaign, have only heightened suspicions about their influence on US policy. Tobias led the US delegation in Gaborone.

WHO strongly favours FDCs and insists that its own standards are based on the same as those applied by the US Food and Drug Administration (FDA).

Lembit Rago, a senior WHO official, told the *Times* that as soon as his assessments office approved Indian-made generic drugs for international anti-AIDS efforts, 'a very cold wind began to blow from the US. It is no secret that Pharma is lobbying against us in a big way'.
— *IPS*

Generic drugs for fighting AIDS

Since the release of President George W. Bush's Emergency Plan for AIDS Relief, the US global AIDS coordinator and former CEO of Eli Lilly, Randall Tobias, and other Bush administration officials have made public remarks that question the quality of generic antiretroviral drugs and undermine international quality standards set by the World Health Organisation.

Médecins Sans Frontières is deeply concerned that the Bush administration will stand in the way of countries and programmes wishing to use funds provided by the Bush plan to purchase affordable quality medicines in general, and triple 'fixed-dose combinations' in particular, despite the fact that they are generally three to five times less expensive than the brand-name versions. These generic drugs have been certified by WHO by meeting stringent international standards for quality, safety, and efficacy, and are manufactured by the same pharmaceutical labs that produce hundreds of generic medicines used by Americans every day.

Fixed-dose combinations of antiretroviral drugs are widely recognised as a key element to efforts to scale up AIDS treatment in developing countries. Based on Médecins Sans Frontières's experience delivering antiretroviral therapy in resource-poor settings, we have become strong advocates of triple fixed-dose combinations. Our clinical results thus far are encouraging.

WHO-recommended triple fixed-dose combinations are available only from generic producers because the patents of the three individual compounds are held by three different companies.

Despite mounting evidence, the Bush administration appears to be ignoring the fact that these newly adapted tools in the fight against AIDS exist today and are being widely used in treatment programmes that are saving lives.

There is no medical or scientific basis for the Bush administration's attacks against WHO prequalified medicines, and the United States is isolated in its view that WHO prequalification standards are not sufficient. We call upon the United States to join the international consensus by allowing its grantees to procure quality generics, including fixed-dose combinations, and by supporting the WHO prequalification project. We cannot stress enough how disruptive it will be if the United States fails to do so.

The only possible explanation we can imagine for the Bush administration's current position on procurement of quality-assured generic medicines is that it is more interested in protecting the interests of the pharmaceutical industry than it is in expanding antiretroviral treatment to the largest possible number of people.

We would like to be proven wrong.
— **Ellen 't Hoen**, Interim director, Campaign for Access to Essential Medicines, *Médecins Sans Frontières*
— *International Herald Tribune* (*IHT*), 2 April 2004

Activists claim partial victory on export of generic drugs

Saul Chernos

Canada is on the verge of passing a law that would allow makers of genetic medicines to produce and export relatively inexpensive versions of patented, brand-name products to developing countries trying to tackle serious epidemics.

On 3 May, Parliament approved legislation formally introduced last November after then-Prime Minister Jean Chretien pledged to legalise the export of generic copies to countries that could otherwise not afford costly brand-name drugs to fight HIV/AIDS, malaria, tuberculosis and other diseases.

The proposed law, which is scheduled for debate and possible ratification in the Senate, Canada's upper chamber, has drawn mixed reviews.

Stephen Lewis, the United Nations envoy for HIV/AIDS in Africa, told IPS the removal of a highly controversial right-of-first-refusal provision is a significant victory for non-governmental organisations (NGOs) and people in developing countries who cannot afford costly patented medicines.

The clause would have given brand-name manufacturers the first right to fill shipment deals arranged by generic firms, leading generic drug makers and humanitarian groups to warn it could lead to brand-name firms blocking exports of generics, potentially pricing medicines out of reach of the people who most need them.

'I've come tentatively to the conclusion that the government has by and large honoured the position it took last September, when it announced the legislation,' Lewis said. He added that time will tell if other amendments to Bill C-9 will unduly restrict the participation of some countries or limit the approved list of medicines.

Richard Elliott, research director with the Canadian HIV/AIDS Legal Network in Toronto,

Africa, AIDS groups blast Bush plan

Jim Lobe

If US President George W. Bush is expecting bouquets from AIDS activists for his proposal to expedite approvals for life-saving anti-retroviral drugs by the Food and Drug Administration (FDA), he is in for a disappointment.

'WHO was asked by its member states to establish an international standard called the prequalification process so that it could play the role of honest broker for both the global North and the global South (in certifying medications for use),' said Paul Zeitz, director of the Global AIDS Alliance. 'Now the US is undermining the credibility of that international program.'

Critics also charged that the administration's new FDA programme appeared designed to give US and western pharmaceutical companies a leg up on their competitors in developing countries whose generic drugs generally cost far less than their brand-name equivalents manufactured by 'Big Pharma.'

At stake are hundreds of millions of dollars that are being allocated by the administration under its five-year, US$15-billion President's Emergency Plan for AIDS Relief (PEPFAR) to procure life-preserving anti-AIDS drugs for 14 African and Caribbean nations that are among the worst-affected by the global AIDS epidemic.

'The concern we have about the "fast-track" FDA approval is that there already is a recognised process which includes many of the exact same steps that the FDA uses,' Zeitz told OneWorld. 'Instead of reinforcing (WHO's) prequalification process, they are slowing things down by creating a redundant and parallel US-led review process.'

Three big US pharmaceutical companies — Bristol-Myers Squibb Co., Gilead Sciences Inc. and Merck & Co, Inc. — announced that they are jointly pursuing development of their own one-dose-a-day anti-AIDS drug, while British-based GlaxoSmithKline and Germany's Boehringer Ingelheim Corp. said they were also considering a co-packaging deal for FDCs (fixed-dose combinations).

Activists said they believe the administration stalled the PEPFAR programme so the brand-name pharmaceutical companies could play 'catch up' with the generic manufacturers in developing their own FDCs. 'The US, while appearing to finally find religion on this issue,' said Health Global Access Project's (Health GAP) Asia Russell, 'continues to buy time to lock in countries and recipients into using only patented drugs. This decision will cost money, time, and lives,' she added.

'The US pharmaceutical industry is behind the game on FDCs, and the White House is stepping in to help them catch up with the more innovative generic producers who have pioneered FDCs,' said Bill Fletcher, Jr., president of TransAfrica Forum in Washington.

— *OneWorld*

said he applauds the deletion of the right of first refusal. 'That was a huge sticking point, and one of our most fundamental criticisms of the bill.'

However, the government added a 'non-commercial' amendment to the bill that would give patent holders the right to sue generic companies that sell a particular drug for more than 25 percent of the Canadian list price. Elliott said this could potentially increase the leverage of brand-name drug companies.

Generic firms would have loopholes. They could argue, for instance, that the price they are charging is in line with their manufacturing costs, plus 15 percent. But, said Elliott, the amendment gives brand-name firms in an already litigious industry yet another reason to go to court — in this case to cancel a generic producer's licence to copy and export a particular patented drug.

'It may or may not be the case that 25 percent of the price is appropriate. But if it goes above 25 percent, then the litigation is invited,' Elliott said. He described the amendment as 'part and parcel of a larger "big pharma" agenda of pushing stronger intellectual property standards.'

Officials say the amendment is intended to ensure prices remain affordable.

'We recognise that the generics should be making some type of return in order to encourage their participation, and we think that 25 percent allows for that,' said Eric Dagenais, director of patent policy with Industry Canada, the government department that led the drafting of Bill C-9.

Twenty-five percent is not a fixed cap, he told IPS, but a figure that would ensure wider scrutiny if it was exceeded.

Brent St. Denis, the Liberal Party Member of Parliament who chairs the committee that reviewed Bill C-9, said the legislation represents a compromise. Brand-name companies 'weren't thrilled' with the removal of the right of first refusal, and the non-commercial amendment addressed what they considered unfair competition, he explained in an interview.

'I think the government has found the right balance between making sure that the generics have the right to do this, and keeping a bit of a downward pressure on prices for the purposes of the bill, which is to get cheap drugs to the countries that need them.'

Also tacked onto the bill is an amendment giving non-members of the World Trade Organisation (WTO) such as Vietnam and East Timor access to generic exports.

Elliott said he appreciates those nations are now included, but he called the wording problematic because countries receiving generic medicines through compulsory licensing would have to first declare a state of emergency and then make their case product-by-product.

'This doesn't make sense from a public health perspective,' Elliott said, adding that it is unethical to wait for an actual emergency before making affordable medicines available.

By applying this measure only to non-WTO countries, Ottawa could be perceived as pressuring them to join the WTO, he added. 'It's contrary to Canada's obligations under international human rights law, where there is a very clear direction that one should never use the issue of access to food or medication as a political bargaining chip.'

Elliott also objects to an amendment that would require NGOs to secure the permission of the government of a country where they are offering treatment in order to import generic medicines from Canada.

But Lewis said governments must be able to set policies and plans for any medical intervention happening within their borders. Some organisations, including Medecins Sans Frontieres (Doctors Without Borders), have a solid reputation and working relationship with governments and should easily be able to secure their support, he added.

'One of the very important safeguards is that we do these things in conjunction with the national plan of the country involved. To ask a government to approve an NGO bringing in anti-retroviral drugs and doing treatment is not a terrible thing to

suggest,' Lewis said.

The only apparent roadblock to Bill C-9 becoming law is a looming federal election. If a vote is announced, both Parliament and the Senate, which ratifies all federal legislation, would shut down and the next government would have to decide if it wants to complete any unfinished business or begin anew.

Chretien's successor, Prime Minister Paul Martin, has said the legislation is a priority for his government, and with the Liberals leading in the polls, the bill seems likely to pass sooner or later. 'In a worst-case scenario you're only looking at losing a couple of months,' St. Denis said, adding that the bill has received broad support from all parties and would likely return to the table fairly quickly if interrupted by an election.

When the bill becomes law, Canada would become the first country to implement what is known as the WTO's 'Aug. 30 Decision'. It allows countries to override patents on pharmaceutical products so that generic companies can export to countries that lack their own drug-making capacity.

While much of the political lobbying appears to have ended as far as the legislation, in many respects the work has just begun. Elliott said he expects some of the same battles will be fought to ensure that regulations stemming from Bill C-9 offer the flexibility needed in order to serve their intended purpose.

'We'll have to see if big pharma tries to derail things when those first applications for compulsory licences come forward,' he added.

Lewis said humanitarian groups will need to tell governments and other interested parties that Canadian generic firms are able to begin making and exporting competitively-priced medicines.

'We're going to need the drugs for the next two generations,' he said. 'Even if it takes a few months now, the drugs are going to be used year after year after year. Potentially there are hundreds of thousands, way into the future, millions, of people who will be treated.'

— *IPS*

Bush undermines AIDS war

Donald G. McNeil Jr.

Three years after the United Nations declared a worldwide offensive against AIDS and 14 months after President George W. Bush promised $15 billion for AIDS treatment in poor countries, shortages of money and battles over patents have kept antiretroviral drugs from reaching more than 90 percent of the poor who need them.

Progress in distributing the drugs, which have sharply cut the death rate in Western countries, has been excruciatingly slow despite steep drops in prices.

In March, Stephen Lewis, the special UN envoy for AIDS in Africa, conceded that the World Health Organisation's ambitious plan to have 3 million people in treatment by 2005 – announced on 1 December, World AIDS Day – was collapsing from a lack of money. Donations to the Global Fund to Fight AIDS, Tuberculosis and Malaria are now about $1.6 billion a year, barely 20% of what UN Secretary General Kofi Annan said was needed when he created the fund in 2001.

While Bush promised in his 2003 State of the Union address to spend $15 billion over five years on AIDS in Africa and the Caribbean, his budget requests have fallen short of that goal. For the most recent donation to the Global Fund, he requested only $200 million, although Congress authorised $550 million.

While lower-priced generic antiretroviral drugs have been approved by the World Health Organisation, endorsed by the World Bank and used in several African countries, the Bush administration has so far paid only for medicines that are still under patent and cost much more.

For example, Daniel Berman, co-director of the Médecins Sans Frontieres campaign for low-cost drugs, said that in Zimbabwe his organisation planned to treat 1,000 patients with drugs from two approved Indian generic makers, Cipla and Ranbaxy Laboratories.

Both companies combine three antiretrovirals so that a day's dose is just two pills and the cost is $244 to $292 per patient per year.

Meanwhile, Berman said, the federal Centers for Disease Control and Prevention in Atlanta plans to pay for the treatment of 1,000 Zimbabweans, buying the same three drugs separately from GlaxoSmithKline, Bristol-Myers Squibb and Boehringer-Ingelheim. The best prices available in Africa from those companies, he said, add up to $562 a year, and a daily dose is six pills.

Advocates of cheap drugs say the Bush administration has yielded to pressure from the pharmaceutical lobby to find ways to reject the generics.

On 26 March, Senator Edward Kennedy, Democrat of Massachusetts, and John McCain, Republican of Arizona, wrote a joint letter to the White House urging it to accept generics approved by the UN health agency. In a separate letter, Representative Henry Waxman, Democrat of California, accused the Bush administration of trying to set standards for Indian generics higher than those for American ones.

— *International Herald Tribune*, 29 March 2004

Malaysia: Law Change Means Cheaper HIV/AIDS Drugs

The cost of the three-in-one combination drug treatment for HIV-infected patients in Malaysia will be reduced to between RM200 and RM220 from June compared to the current RM1,200.

Malaysian Health Minister Dr Chua Soi Lek said the cost reduction came after his ministry amended the Patent Act to enable the patented drugs to be imported from India.

'With the cheaper cost, we can treat at least 4,000 HIV patients compared to the present 1,500,' he said. Dr Chua said there were 58,000 HIV patients and another 8,000 AIDS patients in Malaysia and 93% of them were males. The majority of them were aged between 20 and 39 and drug addicts, but the number of sexually transmitted HIV patients was on the rise.

—*The Star* (M'sia), 7 June 2004

US drug firm hikes price of publicly funded AIDS drug

Recently US health activists petitioned against the company Abbott Laboratories' price hike of AIDS drug Norvir. We publish below excerpts of a letter from six members of the US House of Representatives to the Secretary of the US Department of Health and Human Services in support of the action.

February 27, 2004

Dear Secretary Thompson:

Abbott Laboratories recently announced that it has increased the price of ritonavir, an important AIDS drug marketed under the name of Norvir, by 400%. Ritonavir was discovered under a US government grant. Abbott Laboratories has indicated that only US purchasers will be subject to the price increase. We ask that you take action immediately to protect American AIDS patients and US taxpayers from this blatantly exploitative pricing policy. Several patient groups, AIDS providers and generic drug manufacturers have petitioned you for relief under the federal Bayh-Dole Act.

The facts in this case are extraordinary and warrant extraordinary action by the government. Taxpayer-funded research was instrumental in developing the drug, and the manufacturer's development costs were unusually low due to small, quick clinical trials and expedited government review. The manufacturer has generated more than a billion in sales revenue from the drug, yet has adopted a pricing policy that exploits and discriminates against the very taxpayers who subsidised the development of its product.

Following are relevant details:

♦ Ritonavir was conceived in the performance of grants from the National Cooperative Drug Discovery Group for AIDS (NCDDG-AIDS), administered by the National Institute of Allergy and Infectious Diseases. Abbott Laboratories acknowledges the federal government's rights in six ritonavir and lopinavir patents.

♦ Abbott Laboratories' drug development costs for ritonavir were low because of the short development timeframe and the small number of patients included in clinical trials. FDA completed review and approval of ritonavir in just 70 days. FDA's review was based on three clinical trials (the longest of which lasted 48 weeks) with 1,583 patients. Abbott Laboratories began selling ritonavir as Norvir in 1996.

♦ By the end of 2001, cumulative Norvir sales had already exceeded $1 billion.

♦ Norvir is now primarily used as a 'booster' of protease inhibitor regimes, and is recommended for use in conjunction with six of seven protease inhibitors used in Highly Active Antiretroviral Treatment (HAART) for AIDS.

♦ Abbott Laboratories announced plans last fall to increase the price of Norvir five-fold. For patients who use the most common dose (200 milligrams per day), this is an increase in the average wholesale price of $6,100 per year.

♦ The new pricing policy will impair competition. The manufacturer's planned price increase will apply only when Norvir is used as booster for competitors' products. Abbott did not apply this price increase to Norvir used in its own Kaletra product, a co-formulation of Norvir/Lopinavir used to treat AIDS. By applying the price increase only to its competitor's products, Abbott is seeking to unfairly increase its market share in the protease inhibitor market and distort prescribing practices.

♦ The manufacturer is using pricing policies to discriminate against American AIDS patients and taxpayers. Abbott Laboratories has limited the 400% price increase to the US market. The manufacturer is charging US consumers and third party payors four times more than foreign purchasers (including those in foreign nations classified as high income by the World Bank) for a product developed with US tax dollars.

Abbott Laboratories' exploitation of US AIDS patients and US taxpayers demands quick and decisive action by the Bush Administration.

Clearly there is solid justification in this case for exercising the government's authority to maintain the accessibility and affordability of an essential medical invention. Your failure to provide relief in the case of this important AIDS drug would signal that the federal government will tolerate virtually any corporate misuse of taxpayer-funded inventions.

We support the efforts of the petitioners to make ritonavir more accessible. We hope you will carefully consider the petition before you and exercise your authority for the benefit of American AIDS patients and American taxpayers.

Sincerely,

SHERROD BROWN,
Member of Congress;
HENRY A. WAXMAN,
Member of Congress;
JAN SCHAKOWSKY,
Member of Congress;
ROSA L. DeLAURO,
Member of Congress;
BERNARD SANDERS,
Member of Congress;
DENNIS KUCINICH,
Member of Congress

Africa counts its dead

Lacking drugs, doctors and solidarity, Africa is being subjected to a mounting AIDS toll

Michael Fleshman

The HIV/AIDS pandemic continued its deadly assault on sub-Saharan Africa in 2003, taking an estimated 2.3 million lives, infecting an additional 3 million people, and continuing its relentless spread in all but a very few countries. With education and prevention programmes starved for funds, access to medications limited to the very rich or the very fortunate and victimisation of the infected all too common, Africa and the international community failed to halt the spread of the disease, or ease the suffering and economic and social devastation it has wrought.

The grim findings are contained in an epidemic update released on 25 November by the Joint UN Programme on HIV/AIDS (UNAIDS). The report confirms that Africa remains the epicentre of the global crisis, accounting for almost 80 per cent of the 3 million fatalities worldwide and over 60 per cent of the 5 million new infections.

Despite increased spending on HIV/AIDS programmes and improved responses by many governments, noted UNAIDS Executive Director Peter Piot, 'our current global efforts remain entirely inadequate for an epidemic that is continuing to spiral out of control.' The rapid spread of the human immunodeficiency virus that causes AIDS in Eastern Europe, South and Central Asia and other areas with low infection rates, he said, meant that governments in those regions 'can either act now' to contain the disease 'or pay later -- as Africa is now having to pay' -- in lives and lost development.

HIV/AIDS in Africa and the world (in millions)

	Global	Africa	Africa as % of total
Total HIV infections:	40	26.6	66.5
2003 HIV infections:	5	3.2	64.0
2003 fatalities:	3	2.3	76.6
Percentage of population infected by HIV	1.1	8.0	
ARV treatment	**Requiring treatment**		**Receiving treatment**
Sub-Saharan Africa:	4.1 million		50,000
In all developing countries:	6.0 million		300,000

Source: *UN Africa Recovery from UNAIDS and WHO data.*

African women hardest hit

Although adult infection rates vary widely in Africa, from less than 1 per cent in Mauritania to nearly 40 per cent in Botswana and Swaziland, Southern Africa remains by far the worst affected. The region includes just 2 per cent of the world's population but accounts for fully 30 per cent of all HIV infections. Women aged 15-24 now comprise the majority of new infections in Africa, and are more than twice as likely to contract the virus as young men.

The news is better in Uganda, where years of aggressive education and prevention programmes saw infection rates in the capital, Kampala, drop to 8 per cent, down from 30 per cent a decade ago. A similar approach helped Senegal keep its infection rate stable at about 1 per cent, although rising rates among commercial sex workers in urban areas leave no grounds for complacency.

There are positive developments in Southern Africa too, with South Africa set to join Botswana in providing treatment for HIV and AIDS through the public health system - including antiretroviral drugs (ARVs) that attack the virus itself. Infection rates in Zambia and Malawi appear to have levelled off - although at alarmingly high levels.

New tools lower estimates

But UNAIDS cautions that the stabilisation of infection rates in Southern Africa in particular is misleading - reflecting not a reduction of new infections, but an increase in deaths. In Zambia, for example, the number of new infections was matched by the number of AIDS fatalities in 2003, keeping statistics on infection rates steady as older victims died.

The statistical problem is exacerbated this year by changes in the way UNAIDS and the World Health Organisation (WHO) calculate figures on the HIV/AIDS pandemic. Improved data collection and analytical tools have led these organisations to lower their estimates of infection rates and deaths in 2003 compared to those published in previous years.

Under the new system, the total number of people living with HIV/

Africa Recovery

Tanzanian AIDS sufferer cared for by his mother: In 2003, another 2.3 million lives were lost in Africa.

AIDS, calculated to be 40 million, actually reflects the midpoint between the lowest estimate of people infected, 34 million, and the highest, 46 million. Similarly, the number of African fatalities for 2003, set at 2.3 million, actually represents estimates of between 2.2 million and 2.4 million. The range is much narrower for deaths because of the greater availability and reliability of mortality records.

These changes give the appearance that the global epidemic stabilised or even improved over the past year. Regrettably, the lower figures reflect only the changes in data collection and analysis. When researchers apply the new methods to previous years, the report emphasises, they find a steady increase over time in both infection and mortality rates.

More than 20 years after the first case of AIDS was diagnosed, 'the most devastating social and economic impacts of AIDS are still to come,' cautioned Dr. Piot. Initiatives like WHO's drive to provide 3 million people with ARVs by 2005, combined with expanded education and prevention campaigns, an end to discrimination against people with HIV and much wider use of a simple treatment to prevent mother-to-child infections, he said, would go far to mitigate the worst of those impacts. But to date the world has failed to provide the $10 bn annually that an effective response to the disease would cost. At present rates of infection, the cost of an effective global response to the disease will rise to $15 bn by 2007.

— *Africa Recovery*, January 2004

A Grim Prognosis

Among pregnant women in urban Botswana for example, HIV infection rates that exceeded 38 per cent in 1997 had risen to almost 45 per cent by the end of 2001. In the 25-29 age group, infection rates topped 55 per cent.

The extraordinarily high rates among women in their prime childbearing years have the gravest implications for their children, many of whom will become infected by their mothers or be orphaned as their parents die. Significantly, about half of all new adult infections are occurring among young adults aged 15-24. This is evidence, UNAIDS Executive Director Peter Piot says, that despite two decades of HIV/AIDS education and prevention programmes, 'young people do not have the information and means to protect themselves from HIV.'

That is particularly true for women, who accounted for almost 60 per cent of all new infections in Africa during 2001. A recent study of young people and HIV/AIDS by UNAIDS, the UN Children's Fund (UNICEF) and the World Health Organisation (WHO) found that four out of five young women in Cameroon, the Central African Republic, Equatorial Guinea, Lesotho and Sierra Leone lacked the information needed to protect themselves from the disease. 'The tragic consequence,' noted UNICEF Executive Director Carol Bellamy, 'is that they are disproportionately falling prey to HIV.'

AIDS already accounts for 75 per cent of deaths among Kenyan police and is expected to take the lives of 7,000 teachers in Malawi by the end of the next decade.

Business as usual

Despite the launch of some 100 national AIDS coordinating bodies around the world, many governments and civil society groups struggled to strengthen political leadership, design effective action plans and, most importantly, overcome the desperate shortage of human and material resources. Donors and non-governmental activists remain at loggerheads over funding priorities, drug patent rights and the feasibility of treating the tens of millions of HIV-positive people in developing countries.

But it is the continuing shortfall in international funding for the battle against AIDS in Africa and other poor regions that has attracted the harshest criticism from non-governmental organisations (NGOs) and international health experts. While critics have welcomed the recent increase in aid to developing countries, they charge that the failure to fully fund AIDS programmes in poor countries has needlessly taken millions of lives, and that tens of millions more will die unless adequate resources are provided.

On the eve of the 14th International Conference on AIDS in Barcelona in July 2002, two prominent Northern NGOs, Doctors Without Borders and the Health GAP Coalition, accused wealthy countries of 'wilful neglect' for refusing to adequately fund treatment programmes in Africa. 'The refusal of the European Union and other donor governments to commit funds for lowest-cost medicines has already condemned millions to death,' charged Health GAP founder Dr. Alan Berkman. 'The feasibility of treatment has never been more certain. But as long as wealthy countries refuse to pay, feasibility does not matter.'

The UNAIDS head Piot charged that political leaders in Africa and the world stood and watched while millions of Africans died needlessly. 'The world stood by while AIDS overwhelmed sub-Saharan Africa. Never again'.

— **Michael Fleshman**, *Africa Recovery*, September 2002

The economic and social impact

Belinda Beresford

AIDS has severely affected households in Southern Africa. Family members die or lose their jobs, eroding incomes. When farmers and workers are lost, the economy suffers.

In Southern Africa, as elsewhere in the continent, the AIDS epidemic is not just a health crisis. It is also 'a major threat to development and to human society,' says Executive Director Peter Piot of the Joint United Nations Programme on HIV/AIDS (UNAIDS). While wreaking havoc on the present generation, the disease jeopardises the future as well, undermining African economies and societies in ways that often are not immediately apparent.

Taking a narrow economic approach, however, some have argued that AIDS is unlikely to inflict severe damage on national economies because those infected are, in their great majority, the poor and unskilled, who contribute little in pure economic terms. This view ignores not only the human dimension, but also the broader social and economic aspects of development. It likewise ignores the existing evidence of the many insidious ways in which AIDS already is harming key sectors in those countries most seriously affected by the epidemic.

Harvard University economist Jeffrey Sachs pointed out that HIV/AIDS damages society just as it does the human body: it begins by killing those parts responsible for building society, the women and breadwinners who sustain and safeguard the community as a whole. Ultimately, AIDS undercuts economic growth and harms development, but its impact is felt first at the 'cellular' level, among African households.

Of all parts of Africa, the Southern African region has the highest infection rates. In South Africa and Botswana, 15-year-olds currently have a one-in-two chance of dying of HIV/AIDS. The US Census Bureau in 2000 forecast that Botswana, Zimbabwe and South Africa would experience negative population growth as a result of HIV. Slowly won development gains, such as life expectancy, education and literacy, are being eroded. In Botswana, it has been forecast that HIV will cut in half life expectancy at birth.

South Africa, once seen as the economic powerhouse for the region, is thought to have the greatest number of infections in the world — an estimated one in nine of the population has HIV. The spread of the virus is not expected to peak for another five years, when the estimated number of infected people may rise from 5.2 million to 8.2 million, or nearly 17 per cent of the total population. Such projections, of course, do not take into account new medical breakthroughs or changes in people's behaviours, which could impede the disease's progression.

Families hit hard

Among households, the direct costs of HIV/AIDS can be measured in the lost income of those who die or who lose their jobs because of their illness. Household savings fall, consumption on items other than health and funerals declines and expenditure patterns are distorted as families struggle to cope with the demands of the sick and dying.

Mr. Robert Greener of the Botswana Institute of Policy Analysis told *Africa Recovery* magazine that while government revenue from its diamond industry has been relatively unaffected by the AIDS crisis, that of households has been hit hard. Overall poverty rates will not necessarily get worse, 'but the rate of improvement will not be what it was. We found that HIV will have a major effect on how [people] can invest in their own future.' He estimates that between 17 and 25 per cent of households will lose an income earner in the next 10 years, with total income falling by 15 per cent in the poorest homes. A government AIDS-impact study estimated that overall household per capita income will fall by 8 per cent, and as much as 13 per cent for the poorest quarter.

Households which otherwise might have remained above the poverty line are pushed below it. This in turn can feed the epidemic. As the UN programme, UNAIDS, has pointed out, at least two of the behavioural responses to poverty can exacerbate the epidemic: migration in search of work and employment in the sex trade. When people are mired in poverty, 'taking care to avoid HIV/AIDS may seem a less immediate concern for many people than simple survival.' Combating poverty, in turn, can help make people less vulnerable to AIDS. A study in Bushbuckridge, South Africa, found that providing micro-loans to groups of women gave the women some financial autonomy, enabling them to better negotiate safer sex.

On a wider scale and over time, the erosion of household incomes and opportunities can damage the fibre of entire communities and societies. Extended family networks, which can cope with the normal traumas of life in poor countries, often begin to fray when multiple orphans are dumped on them and when the breadwinners

Africa Recovery

Farmers in Zambia: Loss of a family member to AIDS can push households deeper into poverty.

can no longer support themselves, let alone anyone else. The transfer of knowledge across generations is lost, and socialisation is reduced.

Health facilities under strain

Not only do overall household incomes fall, but also what money remains tends to be diverted to meet the needs of the sick. Family expenditure on healthcare rises, eventually consuming savings and other resources in an attempt to keep death at bay, and to pay for funerals when the battle is lost.

On a grander scale, countries' health systems themselves become overburdened. Already understaffed and underfunded, Africa's health infrastructure is struggling to cope with the enormous demands placed on it. Public health facilities in particular come under strain, as many private clinics and doctors choose not to offer treatment for HIV/AIDS. The lack of supplies can put healthcare workers at risk of becoming infected themselves.

AIDS distorts health-spending priorities. According to UNAIDS, up to 80 per cent of hospital beds in Zambia and Zimbabwe (as well as Côte d'Ivoire) are occupied by HIV-positive patients. For governments, the epidemic poses a number of dilemmas: to spend limited resources on trying to prevent further infections, helping those already infected, or combating other serious health problems, such as tuberculosis, malaria and cholera.

Empty schools

Many poor households affected by AIDS may not be able to afford to send their children to school. Even in countries where schooling is free, there are other costs such as uniforms and books. Specifically to address this problem, the World Food Programme has proposed that 'take-home rations' should be added to school feeding projects to give families an incentive to send their children to school.

Such a programme could particularly help female children, since cultural conditioning means that girls are more likely to be kept out of school to become caregivers. Where HIV infection rates are lower, school attendance, especially of girls, tends to be higher.

Moreover, children may be the only able-bodied members of a household if the adults are sick — or dead — and are likely to concentrate more on survival and raising their siblings than on education. Studies in Zimbabwe have found that of the AIDS orphans on commercial farms, not one was attending secondary school and almost half the primary school pupils had dropped out by the time their parents had died. According to estimates, more than 7 per cent of Zambia's 1.9 million households are now headed by children aged 14 or less.

In some cases, students also may be subject to disproportionately high infection rates. At one South African university, it has been estimated that two-thirds of students will be HIV-positive by the time they graduate. As such students and pupils die, not only do Africa's economies lose potential skilled workers, but the governments' educational investment in them also is wasted. Similarly, families' expenditures on their schooling have been in vain, and they lose not just a loved one, but a possible source of future revenue.

Infection rates among teachers also are high. According to South African economists Peter Badcock-Walters and Alan Whiteside, in 1998 the mortality rate among educators was 39 per 1,000, or 70 per cent higher than in the 15-49 year age segment of the population. In Zambia, during the first ten months of 2000, 1,300 teachers died of AIDS — two-thirds of the annual number of newly qualified teachers.

Macroeconomic impact

In many different ways, the devastation of AIDS among individuals and families ultimately affects a country's overall economic performance. The loss of experienced workers and skilled professionals saps production in key sectors. More insidiously, AIDS can erode the people's morale, weakening their confidence in the future, further harming productivity and undermining their willingness to save and invest.

Foreign investors also are becoming increasingly concerned about the implications of the HIV/AIDS epidemic, at a time when Africa is seeking to attract more international investment. For foreign investors, notes Mr. Gordon Smith, chief economist of Deutsche Bank in South Africa, 'uncertainty means sell rather than hold', much less invest more money.

According to some estimates, annual per capita economic growth in Africa is 0.7 per cent less because of the cumulative impact of AIDS. Such estimates are seriously unreliable, however. There is a paucity of

accurate data both on AIDS itself - precisely who is infected, in which economic sectors - and on how the illness actually affects different economic activities. Nor can the impact of AIDS be easily separated from other factors. 'AIDS is part of a whole. It will have a macroeconomic impact,' admitted Mr. Whiteside, the South African economist. 'But you cannot disimpact AIDS from labour legislation, for example'.

Nevertheless, numerous studies agree that AIDS can seriously slow down economic growth, to varying degrees. UNAIDS has estimated that when HIV prevalence rates rise to more than 20 per cent, gross domestic product (GDP) in those countries can be lowered by as much as 2 per cent a year. In South Africa, the investment bank ING Barings has projected that HIV/AIDS could drag down GDP by 0.3-0.4 per cent a year. Another study has indicated that by the end of the decade, AIDS could have knocked South Africa's GDP by 17 per cent, or $22 bn.

The UN Development Programme (UNDP), in its Botswana Human Development reports, cites government studies that HIV/AIDS will result in GDP being between 24 per cent and 38 per cent lower by 2021. Mr. Greener says that 2 per cent of the workforce in that country is showing clinical signs of AIDS. He predicts that over 25 years, GDP could be 40 per cent lower than without HIV/AIDS. 'There will be an increased cost of skills,' he says. 'There is a need to put in place practices to maintain productivity and prevent a skills-related bottleneck'.

Farm output erodes

The agricultural sector is one of the hardest hit in sub-Saharan Africa, where it is often the largest contributor to the economy. As people sicken, the areas they cultivate may shrink, and yields decline as physical weakness reduces farmers' effectiveness. Food security is jeopardised, as labour, time and money are diverted to deal with the illness. Agricultural households may revert to subsistence rather than cash crop farming, and the quality and quantity of food may decline.

Africa Recovery

Loss of income when adults become ill or die from HIV/AIDS affects household consumption and increases the vulnerability of children.

In Malawi, death rates among employees of the Ministry of Agriculture and Irrigation have doubled, almost all because of HIV/AIDS. In Namibia, studies indicate that agricultural extension workers spend a tenth of their time attending funerals.

'The effect of AIDS on food production is both immediate and long-term,' Dr. Piot of UNAIDS has pointed out. This has been confirmed concretely by a study from Zimbabwe, which looked at the impact of an adult death on the household's ability to produce different foods. It estimated reductions of 61 per cent for maize, 49 per cent for vegetables and 37 per cent for groundnuts. But AIDS also hits long-term agricultural capacity. Livestock is often sold to pay funeral expenses, and orphaned children often lack the skills to farm or look after livestock in their care.

High infection among miners

The mining industry is notorious for its high rates of HIV infection, particularly where there are single-sex hostels and attendant male-to-male sexuality and commercial sex. Migrant labour adds to the problem, with workers carrying infection to and from their employment on trips home, including in other countries. Areas of Lesotho are now being devastated by HIV as sick workers return from South African mines, a situation exacerbated by the economic reliance of the small country on their remittances.

Southern Africa: labour force losses due to HIV/AIDS (%)

	by 2005	by 2020
Botswana	-17.2	-30.8
Lesotho	-4.8	-10.6
Malawi	-10.7	-16.0
Mozambique	-9.0	-24.9
Namibia	-12.8	-35.1
South Africa	-10.8	-24.9
Tanzania	-9.1	-14.6
Zimbabwe	-19.7	-29.4

Source: UN Africa Recovery from ILO and UN Population Division data.

Although there have been anecdotal reports of infection rates as high as 60 per cent, some mining companies say this is exaggerated and claim rates among their employees are close to the national average. The mining companies in South Africa are regarded as being at the forefront of businesses taking action on HIV/AIDS.

In Botswana, the highly mechanised diamond sector, which uses a smaller and more stable workforce, is likely to be relatively unaffected by HIV, unlike the gold mines in neighbouring South Africa. Few families realise direct earnings from diamonds and most of the revenue from the sector goes to the government. It therefore filters into the rest of the economy only through government expenditure. Thus, to an even greater extent than in many other countries, GDP, in per capita terms, does not reflect personal incomes. 'Government is shielded, but people are not,' observes Mr. Greener. 'So that impact falls on the household'. — *Africa Recovery* (June 2001)

Famine and AIDS: A lethal mixture

John Nyamu

A recent UN joint mission to countries in Southern Africa discovered that a new disaster looms in a region caught in a vicious spiral as HIV/AIDS strikes the productive farming population. Hunger, disease and death affect food production, which in turn creates more malnutrition, famine and disease, jeopardising agriculture and the food security of millions.

As Southern Africa's HIV/AIDS infection rates combine with widespread famine conditions, the region faces not only sickness and starvation, but also a severe long-term threat to its economies and societies. This twin onslaught of disease and hunger has dire consequences for families, communities and production systems. Agriculture, Africa's economic mainstay, is being hit especially hard.

The focus of Africa's latest food emergency is not only the arid, drought-prone Horn of Africa or Sahel regions, but also Southern Africa. Most of its countries are largely fertile, well watered and traditionally self-sufficient in food. One reason for Southern Africa's current crisis is that the region also has the world's highest HIV infection levels.

The Joint UN Programme on HIV/AIDS (UNAIDS) estimated that infection rates in 2002 ranged from 15% of adults in Malawi up to more than 30% in Swaziland and Lesotho and a staggering 39% in Botswana.

Meanwhile, the World Food Programme (WFP) estimates that, as of March 2003, the number of people requiring food assistance in Zimbabwe stood at 7.2 million, or 52% of the population. Nearly eight million more also need food aid in Malawi, Zambia, Lesotho, Mozambique and Swaziland.

A new kind of famine

Returning from a tour of the region in January 2003, Mr. Stephen Lewis, the UN Secretary-General's special envoy for HIV/AIDS in Africa, noted that a new kind of crisis has developed in the region, with food shortages and agricultural decline strongly influenced by HIV/AIDS. In all the countries visited, the epidemic has taken a heavy toll on the most productive people — those between the ages of 15 and 45 years. It also has worsened the effects of agricultural mismanagement and poor governance.

Mr. Lewis's trip to Lesotho, Malawi, Zambia and Zimbabwe was part of a joint mission with WFP Executive Director James Morris, who is also the Secretary-General's special envoy for humanitarian needs in Southern Africa.

Describing the pandemic as 'the most fundamental underlying cause of the Southern African crisis', the two officials said it is changing the nature of famine in Africa by cutting agricultural productivity, sapping the population and undermining people's ability to recover from natural and man-made shocks.

As farmers fall ill, physical weakness reduces their effectiveness and the area they cultivate shrinks, leading to declining crop yields. Food security is simultaneously jeopardised by the diversion of labour, time and money to deal with the illness. Agricultural households revert to subsistence rather than cash crop farming, bringing a fall in household incomes and the capacity to buy food. Family expenditures on health care rise, eventually consuming savings and other resources.

Africa Recovery

Africa is losing many of its younger and most productive people to HIV/AIDS.

'The effect of AIDS on food production is both immediate and long-term,' UNAIDS Executive Director Peter Piot has pointed out.

Some effects are very direct. As of 2001, the UN Food and Agriculture Organisation (FAO) estimated that 7 million of Africa's agricultural workers already had died of AIDS, and that 20 million more may succumb by 2020. Such deaths will seriously deplete Southern Africa's agricultural labour force — and thereby reduce the region's ability to grow food or other crops.

A study in a communal area in Zimbabwe has demonstrated that

an adult death from the disease can immediately reduce a household's ability to produce different foods. The declines average 61% for maize, 49% for vegetables, 47% for cotton and 37 % for groundnuts. In Malawi, death rates among employees of the Ministry of Agriculture and Irrigation have doubled, almost all because of HIV/AIDS. In Namibia, studies indicate that agricultural extension workers spend one-tenth of their work time attending the funerals of people who died of AIDS.

In the long term, orphaned children often lack the skills to farm or look after livestock under their care, and households may be forced to sell their livestock to pay for funeral expenses. On a wider scale, extended family networks, which usually cope with the normal traumas of life in African countries, begin to fray under the weight of orphaned young relatives, as breadwinners can no longer bear the extra costs. It is not unusual for a grandmother to care for 20 orphans.

Women hit hard

One aspect of the crisis in Southern Africa has been its disproportionate impact on women. The mission report noted that the prevalence of HIV infection is highest among women and girls, who generally take on nearly all the responsibilities of caring for the sick and orphaned, in addition to their regular obligations to provide food for their households. Yet, the report adds, 'very little is being done to reduce women's risks, to protect them from sexual aggression and violence, to ease their burdens or to support their coping and caring efforts.'

UN Secretary-General Kofi Annan raised the same concern at the Africa-France Summit in February 2003, highlighting the clear gender dimension to AIDS-related food insecurity. Women care for the young, old, sick and dying, he said, and they nurture social networks that help societies share burdens. 'In the past, it was their expert knowledge of alternative foods that kept their families going during

Millions in countries threatened by African famines

Africa Recovery

times of drought. Yet with AIDS rising dramatically and disproportionately among women, that lifeline is being threatened'. He cited 2002 estimates to emphasise the dramatic spread of HIV/AIDS among women. For the first time, he noted, women make up some 50% of HIV-positive people worldwide, with the share rising to 58% in sub-Saharan Africa.

Meanwhile, a study on HIV/AIDS and African agriculture by the FAO has shown that with the deaths of increasing numbers of male farmers, rural women, who are already overburdened, are becoming responsible for even more tasks. 'These structural changes in smallholder agriculture,' concluded the study, 'are likely to contribute to increased malnutrition and an overall decline in the nutritional status of a growing number of resource-poor farmers, particularly women and children, with far-reaching consequences for the health and productivity of the agricultural labour force'.

'Grinding down'

Mr. Lewis associated AIDS with 'the grinding down of society', stressing that the decay of Africa's agricultural sector could be a harbinger of worse to come. Among countries on his tour, Malawi offers a graphic illustration. While several rivers crisscross the lush, green countryside and Africa's third-largest lake forms its eastern border, Malawi is losing people to work its fertile land. It has an annual rate of 70,000 deaths from AIDS-related illnesses (including tuberculosis, malaria and cholera), and life expectancy has fallen from 46 years to 36 years, according to the UNDP. Partly as a result, Malawi has sought emergency food assistance, including donations of maize — the key staple of East and Southern Africa.

In the mountainous kingdom of Lesotho, HIV/AIDS has exacerbated the impact of the crop failures of the last two years, caused by unusual weather patterns. Rains have come too early or too late. Hailstorms, tornadoes and even summertime frost have damaged newly sprouting maize. Lesotho has the world's fourth-highest HIV infection rate, with nearly one-third of working-age adults infected with the virus. 'We're told repeatedly by donors that we don't have capacity. I know we have no capacity; give us some help and we'll build the capacity,' Prime Minister Pakalitha B. Mosisili told Mr. Lewis when the mission

visited the country.

In Zimbabwe, some 2.2 million people are infected with the virus, of whom 600,000 have developed full-blown AIDS. According to the Ministry of Health, 70% of hospital admissions are HIV-related. Expressing concern over the government's lack of capacity or willingness to address the deepening crisis, the mission report predicted that Zimbabweans would become more vulnerable throughout 2003 because 'it is clear that 2002/2003 agricultural production will fall far short of national needs'. The deficit is expected to also affect neighbouring countries, many of which have previously depended on food imports from Zimbabwe, particularly in times of drought.

The drought has been particularly severe in Zambia, where the HIV/AIDS pandemic has not only devastated agricultural production and depleted the work force, but also affected every other aspect of life and society. Some 40,000 to 90,000 people had died of AIDS by the end of 2000, most of them men between the ages of 20 and 45, according to one study. The epidemic's particularly high toll on the country's teachers has been aggravated by the high social stigma surrounding the disease.

'Mass murder by complacency'

Although heartened by African leaders' new willingness to discuss the epidemic, Mr. Lewis pointed out that money remains a critical missing element. He called the lack of resources to fight the epidemic 'mass murder by complacency,' and said that those who watched it unfold 'with a kind of pathological equanimity' must be held to account.

Echoing the special envoy's concern about international complacency, Mr. Richard Feachem, executive director of the UN's Global Fund to Fight AIDS, Tuberculosis and Malaria, wrote in a *Washington Post* commentary: 'The world's failure to fully fund our efforts – or any comparable effort – is yet another indication that people lack the sense of urgency this crisis demands.' The Global Fund has agreed to support programmes worth $1.5 billion over the next two years in more than 80 countries. But to carry out further essential activities, it needs an additional $2 billion in 2003 and $4.6 billion in 2004.

Attention to nutrition

Proper nutrition for people living with HIV is another basic issue that is rarely addressed. The FAO and WHO have jointly published a manual, *Living Well with HIV/AIDS*, which offers dietary suggestions for people with HIV/AIDS. (Available online at: <www.fao.org/DOCREP/005/Y4168E/Y4168E00.htm>).

'The relationship between HIV/AIDS and malnutrition is a particularly extreme example of the vicious cycle of immune dysfunction, infectious disease and malnutrition,' said Dr. David Nabarro, WHO executive director for sustainable development and healthy environments, in February 2003. According to Mr. Kraisid Tontisirin, director of FAO's food and nutrition division, 'The nutritional aspect of HIV/AIDS has been ignored for a long time. The attention was always focused on drugs'.

Dr. Graeme Clugston, director of WHO's department for nutrition in health and development, also affirms the need to pay special attention to the relationship between nutrition and HIV/AIDS: 'The effect of HIV on nutrition begins early in the course of the disease, even before an individual may be aware that he or she is infected with the virus'.

Pointing out the effects of AIDS on nutritional well-being – including reduced nutrient absorption, disruption of appetite and metabolism and wasting of muscles, organs and other tissue – the manual emphasises that eating considerably more food helps to fight the illness and make up for weight loss. A balanced diet requires more protein to rebuild muscle tissue, more energy-rich foods for weight gain, immune system-boosting vitamins and minerals and water to combat dehydration, it adds. Herbs and spices can stimulate a sluggish appetite or digestion and may have other beneficial effects. However, with extreme poverty widespread in Southern Africa, many people cannot afford to buy the right kinds of foods.

New approaches needed

Amid the harsh realities of HIV/AIDS, particularly in Southern Africa, no single action will make much headway. A combination of actions is needed, experts say: against HIV/AIDS, hunger and rural poverty, and for improved agricultural systems and social services.

The joint mission to Southern Africa suggested combining food aid with far-reaching agricultural development strategies and labour-saving technologies that increase resilience to erratic rainfall. It recommended help to generate income and restimulate local food production without adding extra burdens to households affected by HIV/AIDS.

'Relevant actions in education, health, nutrition, water, hygiene and sanitation-related interventions will also be necessary,' the mission report said. 'The pandemic's steady weakening of national governments and its erosion of their social services call for measures that go beyond building capacity; it is also time to speak of capacity replacement and replenishment.' The mission called for long-term measures to strengthen coping skills and ease the burdens on poor and vulnerable households and social groups in order to prevent repeated food shortages.

Mr. Annan told the General Council of the International Fund for Agricultural Development (IFAD) that emergency responses to immediate food crises must at the same time be accompanied by long-term development and health initiatives. 'We must,' he said, 'combine food assistance and new approaches to farming with treatment and prevention of HIV/AIDS'.

– *Africa Recovery* (May 2003)

Is it wilful genocide?

The Durban AIDS Conference in 2000 was informed that unless serious measures are taken, Africa faces an impending catastrophe of unparalleled extent, which will far exceed the bubonic plague that devastated Europe in the 14th century. How did this tragedy happen? *RAHAB HAWA* reports.

At the 13th International AIDS Conference in Durban, South Africa, Karen Stanecki of the US Census Bureau projected that AIDS deaths and the loss of future population from deaths of women of childbearing age mean that by 2010, sub-Saharan Africa will have 71 million fewer people.

Life expectancy will fall from about 60 years to around 30 years for the worst-affected countries, and the rate of population growth will stagnate or turn negative for several countries in the region.

Life-expectancy projections presented show that by 2010, it will fall to 29 in Bostwana; 30 in Swaziland; 33 in Namibia and Zimbabwe, and 36 in South Africa, Malawi and Rwanda. Without AIDS, it would have been around 70 years of age in many of these countries.

It was revealed that, by 2003, the populations of Botswana, South Africa and Zimbabwe would begin to fall because of AIDS deaths and dropping fertility rates resulting from the pandemic.

According to the Director of the White House Office of National AIDS Policy, 'We are at the beginning of a pandemic, not the middle, not the end. We certainly know before we're able to stop this pandemic, we'll have hundreds of millions of people infected and dead and that's the best-case scenario.'

How does one explain this ongoing genocide in Africa? Why was it allowed to happen in the first place? Why was nothing done despite the warnings for more than 15 years?

Recent reports reveal that the US government, including the US Centres for Disease Control (CDC), and the World Health Organisation (WHO) were aware of the threat of the global AIDS epidemic but were in a state of denial.

According to the *Washington Post* dated 5 July 2000, two CIA officers produced a report in 1991 entitled 'The Global AIDS Disaster', which projected 45 million cases of AIDS infections by 2000 – which are fatal, and the great majority of it being in Africa.

This report, known as *Interagency Intelligence Memorandum 91-10005*, which 'foretold one of the deadliest calamities in human experience', was received with mere 'indifference', according to the principal author.

In the course of undertaking the study, the two officers, Katherine Hall and Kenneth Brown, told the *Washington Post* that they had encountered numerous obstacles. Speaking of one military colleague at the National Intelligence Council, Brown said: 'His penetrating analysis was "Oh, it will be good, because Africa is overpopulated anyway"'.

More than anything else, there was no serious international effort to tackle the AIDS problem. In fact, there appeared to be a deliberate policy of not doing anything.

According to the *Washington Post* expose, 'for a decade, the world knew the dimension of the coming catastrophe and the means available to slow it individually and collectively, most of those with power decided not to act'.

According to the Director of AIDS Prevention at the CDC: 'We saw it coming and we didn't act as quickly as we could have. I'm not sure what that says about how seriously we took it, how seriously we took lives in Africa'. There was no urgency to act.

In fact, the rich countries had lost interest in AIDS, once AIDS 'was no longer a threat to the West', said Michael Merson, who would later head WHO's AIDS programme. 'In the 90s, it became clear we were not going to have a major heterosexual epidemic in the States,' he explained.

Sources made available to the *Washington Post* revealed that the director of population, health and nutrition in the US Agency for International Development (USAID) acknowledged that there was 'the lack of political will and resources to combat the spread of HIV' and 'decisions made by policy-makers and program administrators ... were simply the product of a different world view and set of priorities'.

This state of affairs was found to plague WHO as well. According to the *Washington Post* report, WHO's global AIDS programme (UNAIDS) did not receive the support of the new Director-General Hiroshi Nakajima, who succeeded Halfdan Mahler when he retired in 1988. Nakajima was accused by the Director of UNAIDS, Jonathan Mann, of obstruction that 'paralysed our efforts completely'. With the resignation of Mann, WHO's AIDS programme fell apart.

The AIDS epidemic was not on the list of Nakajima's priorities. By virtually ignoring the seriousness of the disease, WHO had undermined any effective global strategy to stop the spread of the AIDS pandemic.

Earlier in 1990 and 1991, WHO had projected that tens of millions of people would die of the disease by 2000.

International agencies, like the World Bank, even found a 'silver lining' in the AIDS disaster sweeping Africa. In an internal World Bank study in June 1992, it was stated that 'if the only effect of the AIDS epidemic were to reduce the population growth rate, it would increase the growth rate of per capita income in any plausible economic model'. Speaking to the *Washington Post*, South African economist Alan Whiteside said, 'Only the World Bank would put that on paper'.

This shameful catalogue of utter indifference, wilful neglect, and denial of the looming calamity continues.

James Sherry, director of programme development for UNAIDS, says it plainly: 'I can't think of the coming of any event which was more heralded to less effect. It still hasn't changed. In terms of real deployment of resources, it hasn't changed. The bottomline is, the people who are dying from AIDS don't matter in this world.'

More shocking is the revelation that the AIDS pandemic was a deliberate policy to depopulate Africa and elsewhere.

According to Jeffrey Steinberg, writing in the *Executive Intelligence Review* of 11 August 2000, the battle against AIDS is a fight against the powerful international economic and political forces which are bent on reducing the population of Africa.

A study commissioned in 1974 by then US National Security Advisor and Secretary of State Henry Kissinger, the *National Security Study Memorandum 200 (NSSM-200)*, which was declassified in late 1989, stated that: 'The political consequences of current population factors in the LDCs (less developed countries)... are damaging to the internal stability and international relations of countries in whose advancement the US is interested, thus creating political or even national security problems for the US'.

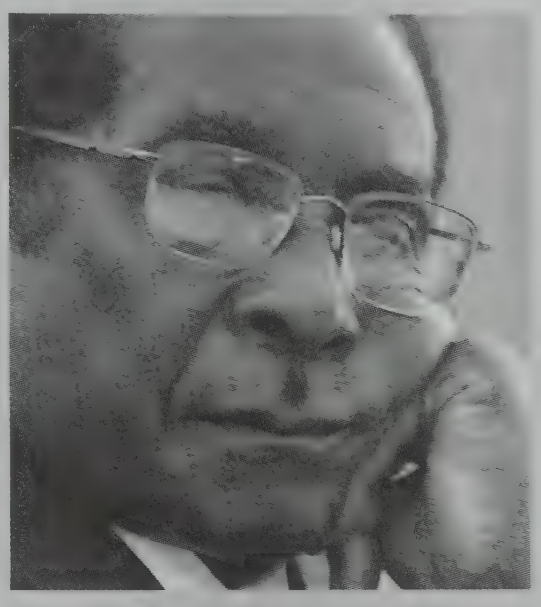
The study went on to say that 'world population growth is widely recognised within the government as a current danger of the highest magnitude calling for urgent measures'.

Further to this, Steinberg's article quotes Peter Schwartz, a former executive of the Royal Dutch Shell group and founder of the Global Business Network, who had done a study in 1986 on AIDS for AT&T, Royal Dutch Shell and Volvo. According to Schwartz: 'We concluded that people who have AIDS in Africa should not be kept alive; they spread the disease. It is better they should die quickly'.

Meanwhile, AIDS in Africa rages on, threatening the future of the continent.

Rahab Hawa works for the Third World Network.

Mugabe: AIDS has hit my family



Zimbabwean president, Robert Mugabe, admitted for the first time on 16 June that members of his family had been affected by HIV/AIDS.

Mr Mugabe told a conference on AIDS that unnamed members of his family had become ill from the disease. Describing HIV/AIDS as 'one of the greatest challenges facing our nation', he said that most people had been affected 'and that includes the extended family of the president himself'.

The admission came after years of official neglect of a virus that has infected almost a quarter of adults in Zimbabwe, one of the highest prevalence rates in the world. In 2003 1.8 million Zimbabweans were infected and a recent survey found that 51% of prisoners were HIV-positive.

As many as 3,000 people in Zimbabwe die of AIDS-related illnesses each week, a toll largely blamed for a drop in life expectancy to 36 years. Figures released in June showed that 135,000 people died of AIDS last year.

Mr Mugabe was speaking at the country's first AIDS conference, which was designed to enable officials, health workers and community groups to draw up a strategy to fight the disease.

His revelation put him in the company of Nelson Mandela, South Africa's former president, who broke a taboo by speaking publicly of losing relatives to the disease.

Other former presidents have gone further by specifying that they lost not just members of their extended family, which in Africa can be large, but close relatives. Zambia's Kenneth Kaunda said his son had died of AIDS and Malawi's Bakili Muluzi his brother.

Mr Mugabe also asked the private sector for help. 'There is no doubt that HIV and AIDS is one of the greatest challenges facing our nation. The disease does not respect status, it does not respect colour ... It is a war that belongs to all of us,' he said.

'We appeal for the greater participation of the private sector. I believe there is scope for [the] government and the pharmaceutical companies to work together so as to bring the prices of the drugs down and enable more of our people to benefit'.

The UN, a co-sponsor of the event, said economic hardships had led people, particularly women, to take sexual risks.

'The fact that it has taken us this long just to hold a conference shows how much the government has neglected the suffering caused by AIDS,' said one delegate, a doctor.

Only about 5% of the population has come forward for testing, reflecting a continent-wide reluctance to know one's HIV status.

In a rare display of unity in May, nine government and opposition MPs went for voluntary counselling and testing, prompting critics to ask when the president would make a high-profile gesture of his own.

The government denies accusations it has lacked the political will to deal effectively with the crisis, first reported in Zimbabwe 18 years ago. — *The Guardian* (UK), 17 June, 2004.

The impact of HIV/AIDS on human capital

C.N. Mwikisa

HIV/AIDS is undermining earlier achievements from investment in education and training and at the same time making new investment more problematic. Human capital in Africa is being heavily impacted by the HIV/AIDS epidemic. While other resources are only affected indirectly by HIV/AIDS, human capital is the entry point of the epidemic into the production system. The ILO argues that Africa's prospects for development are endangered more than anything else by the annihilation of its labour force by HIV/AIDS and the associated deterioration of education and training. This article discusses the effects of HIV/AIDS on human capital and outlines a research agenda to address the problem.

For those who come from sub-Saharan Africa the temptation to question or deny the HIV/AIDS figures can be immense. However, even when low-estimate scenarios are examined, the region still accounts for over 70% of the epidemic.

In Zambia, for instance, 1,300 teachers died of HIV/AIDS in 1998. This was equivalent to two-thirds of the country's annual production of teachers. Assuming the loss remains constant Zambia will have to more than treble its output of teachers every year just to replace those lost to AIDS. Even if this were possible it would still not cover the loss adequately, as it takes time for new teachers to gain the experience that has been lost through the death of their seniors.

In the health sector more resources are being diverted towards HIV/AIDS care and more and more beds occupied by AIDS patients. In other words already-scarce healthcare resources are increasingly being diverted to the care of HIV/AIDS patients at the expense of other healthcare needs.

In agriculture production is declining as labour and other inputs decline, and as extension workers are also impacted by the scourge. In the business sector absenteeism has increased, as have employee turnovers, training costs and healthcare costs. All these have led to a decline in productivity.

HIV/AIDS-related expenses are direct and indirect payroll taxes. Direct taxes consist of the direct costs for treatment of sick employees and for more expensive health and insurance benefits. Indirect taxes include the costs of absenteeism, increased recruitment and training costs and lower productivity.

According to a UNAIDS assessment of one sugar company in Kenya, employee illness resulted in 8,000 days of lost labour over a period of two years, a 50% decline in output, a 500% increase in workers spending on funerals and a more than 1,000% increase in medical costs. A case study of the Debswana mining company in Botswana revealed similar impacts.

Clearly the HIV/AIDS epidemic is devastating economic growth and development in sub-Saharan Africa. It has affected individuals and households, companies and whole economies. Research indicates that when a country has a prevalence rate of 20%, annual GDP growth drops by an average of 2.6% per year. In sub-Saharan Africa as a whole the rate of economic growth has dropped by an estimated 2-4% due to HIV/AIDS. According to the World Bank, countries with high prevalence rates have lost between 0.5% and 1% of per capita gross domestic product per year.

Life expectancy has declined as the HIV/AIDS death toll has increased. In Zambia, for example, average life expectancy at birth has declined to 37 years. Other countries in the region have been only slightly less devastated. In Tanzania overall life expectancy has been cut by eight years, in Rwanda by seven years and in the Central African Republic by six years. In Zimbabwe, Burundi, Malawi, Kenya and Uganda the reduction has ranged from three to five years.

However, an analysis of individual countries shows some marked differences. While prevalence rates have generally been on the increase, Uganda and Zambia show some marked declines. Within sub-Saharan Africa there are also some marked differences between regions. Prevalence rates are extremely high in southern Africa, but comparatively low in West Africa. One major difference between the two regions is that one is mainly Christian while the other is mainly Muslim. Could this be an explanatory factor, or could the explanation lie in the nature and levels of response to the HIV/AIDS scourge in the two regions? Whatever the differences between countries and regions, HIV/AIDS is a national disaster across sub-Saharan Africa.

The human cost

The development impact of HIV/AIDS is well summarised by Nelson Mandela when he states that AIDS kills those on whom society relies to grow the crops,

Africa Recover

HIV/AIDS erodes human resources and productivity essential to a nation's development.

work in the mines and factories, run the schools and hospitals and govern countries. It seriously erodes human capacity and adversely affects what is called capacity deepening - building on existing skills in order to increase future productivity.

There is a growing literature which identifies human capital as the key element in growth and development. The Economic Commission for Africa (ECA) makes this point very clearly:

'There is a solid professional consensus that human capital plays an equal, if not a greater, role in the development process. It is almost invariably the case that countries that have achieved the fastest rates of growth are those that invested most in their people, especially in health, nutrition and education. The link between these factors and productivity, which is the basis for growth, has been sufficiently demonstrated. Human development contributes directly to the well-being of people; ensures a more equitable distribution of the benefits of growth; maximises the linkages between various types of investment in development; and permits a more efficient exploitation of physical capital and other resources.'

The biggest tragedy in sub-Saharan Africa today is the negative impact of HIV/AIDS on the development of human resources. HIV/AIDS reduces both the human capital stock and the ability to create more human capital. When the infected become ill, the value of their human capital is reduced and so is their capacity to produce more human capital by passing on knowledge and skills to others.

Teachers provide the clearest example. Illness and deaths from AIDS decrease the number of teachers available and lead to a fall in the number of school graduates. Where this is avoided through larger classes, the quality of education suffers and the value of the human capital produced by the education system falls. The result is either reduced output or lower-quality products.

Current interventions

In order to avert or soften some of the impacts of HIV/AIDS, governments and NGOs in the region and elsewhere have developed three main groups of interventions: prevention, treatment and care and support. However these interventions fail to adequately address the issue of declining human capital. If sub-Saharan African countries are to achieve the goals of development and poverty reduction, they have to design interventions that reduce the impact of HIV/AIDS on human capital and create more human capital.

While prevention, treatment and care and support go some way to ensuring that some level of human capital is maintained, they still fall short in creating capacities that will produce enough human capital to replace the lost capital. As we have seen, for example, Zambia needs to train twice as many teachers as previously to make up for the effects of HIV/AIDS.

This raises a number of questions. Has the country got enough resources (infrastructural, human and financial) to double its output of teachers? Are there enough secondary school graduates to enrol in colleges and universities? These questions can be posed at every level and type of education or training in every sub-Saharan country. Unfortunately almost no research exists indicating losses in human capital-building institutions.

Research needed

It is not yet clear how much human capital and human capital-building capacity the countries in sub-Saharan Africa are losing. It is not yet clear how the human capital in the main capacity-building institutions — primary and secondary schools, colleges, universities and other research institutions - is being impacted. However it is essential that the capacities of these institutions are strengthened so that they can be in a position both to replace human capital lost to AIDS and produce more human capital for growth.

It is vital therefore to include studies of the impacts of HIV/AIDS on human capital in research agendas. The basic aim of these studies should be to determine the actual impacts of HIV/AIDS on human capital in a number of countries in the region, particularly in the human capital-building institutions, and to develop appropriate responses to sustain human capital, particularly in terms of the necessary investment levels to maintain human capital and ensure adequate technological transfer.

Other important research questions include the extent to which human capital-building capacities have been impacted by HIV/AIDS and the different coping strategies that have been developed in different countries. We also need to study the impact on affected

human capital, and their coping strategies. We need to ask whether sub-Saharan African countries have the capacity to cope with and overcome the effects of HIV/AIDS, and, if not, what needs to be done to build the required capacity. How can productivity in these economies be maintained? What systems should be put in place to ensure better tracking of morbidity, mortality, productivity and so on? What are the emotional impacts of HIV/AIDS, and what are the effects of low morale, stress and isolation on productivity?

Given the current prevalence rates, what are the projections for human capital? What implications do these projections have for human capital planning and development? How can the stock of human capital be maintained given the impact of HIV/AIDS on capacity in the education sector in particular? Are education and training systems making adequate provision to replace the loss of skills in the workforce?

These studies are vitally important if sub-Saharan Africa is to improve competitiveness. While the fight to convince the North to open its markets must continue, the South should also put appropriate measures in place to build the necessary capacities. While brain drain has impacted heavily on sub-Saharan Africa, the impact of HIV/AIDS is likely to be more than we can currently imagine.

A research agenda would be invaluable to research funding organisations, national governments and international organisations as they plan and implement programmes to address the specific needs of African countries. Studies of this nature can also lead to the development of simple methodologies to assess the impact of HIV/AIDS on human capital. They can also lead to a better analysis and understanding of the shifting burdens of human capital development.

C. N. Mwikisa is with the Economics Department, University of Zambia. The above is excerpted from an article which appeared in *CODESRIA Bulletin*, Special Issue 2,3 & 4, 2003.

Business reeling under HIV/AIDS impact

James Hall

HIV/AIDS has not been seen as only a medical problem since the 1990s. The disease's negative economic impacts on businesses in Southern Africa are being confirmed by surveys conducted by health and business groups.

'The anecdotal evidence all employers and workers share, which tells how AIDS is really devastating the workplace, is being supported by scientific surveys,' says Mozambican AIDS activist Simeo Sithole.

Results of a new survey taken by the Bureau of Economic Research (BER) of South Africa were compiled between October and November 2003. Data shows a regional business community reeling under the impact of a disease that is robbing them of employees, negating years of expensive training, and cutting into productivity.

AIDS has profoundly shaken up the way business and industry operated in Southern Africa. There are serious consequences to the goal of full employment. 'Because of AIDS, some employers are seeking to find alternatives to human labour,' said unionist Brandon Simelane of Manzini, Swaziland.

The economic researcher's survey found that 90% of companies included in the study suffered some kind of adverse impact due to AIDS. With statistical error plus or minus 5%, that means it is possible that virtually every business and industry in the region has been adversely hit by the disease.

Industries and agriculture in the productive end of the economy, as well as the transportation industry, are being impacted more than the retail and services sectors where products are sold and maintained.

The prevalence rate for AIDS officially is 25% in eastern South Africa, nearly 40% in Botswana and Swaziland, and well above 20% in the other nations of the 14-state Southern African Development Community (SADC).

Struck as they have already been by AIDS, businesses in the region foresee a glum future as the disease continues to cut into their profitability as well as their workforce. Nearly half of the companies surveyed feel that five years from now, AIDS will still be having a deleterious effect on their operations. The effect on unemployment caused by AIDS is threefold.

Firstly, workers find themselves convalescing at home when they fall sick from the disease. If they are paid on a daily or piecemeal basis, this means they are in effect jobless from loss of income. As their illness persists, they become literally jobless, but too young to receive pensions.

Only a few workers or employees in the region are fortunate enough to have health or unemployment insurance.

'Rather than being a breadwinner, these household heads become a burden to their families,' said one social welfare worker in Lesotho.

Secondly, there is a need by businesses to find healthy new workers to replace those lost to AIDS. But this is a temporary situation, economists foresee.

One of the most common sights throughout Southern Africa is the sign hanging from factory gates or the front doors of stores and business establishments: 'Kute Umsebenti,' which means, 'No jobs.'

Africa Recovery

Work shadowing

But the BER survey found 18%of regional businesses expect to add staff this year. The reason is not that their businesses are doing well and they need to expand. On the contrary, many countries are mired in economic recession.

Rather, the reason for the new hiring is simply to replace deceased workers and employees who have succumbed to AIDS. The hiring practice is called 'work shadowing'.

'An 18% rise in employment would be Godsend to the region,' said an economist with the Central Bank of Swaziland, where formal sector employment currently stands at around 40%.

'But no new jobs are being created by the economy. It is simply attrition: companies scrambling to find able-bodied workers to replace their dead ones. It's a gamble for companies, because by law they cannot administer blood tests to prospective workers, or demand confidential medical information. There is no way for an employer to know if the person he is hiring, and who he is about to invest time and money training, will be gone next year because of AIDS,' the economist said.

The BER report also notes that while 18% of companies expect to add new staff, this is a majority number compared to the 90% of companies that have been adversely impacted by AIDS.

The implication is that most companies may not be replacing their employees who have dropped out of the workforce because of AIDS. This means a probable net loss of jobs in Southern Africa.

The third way AIDS is impacting on regional workers is the prospect of future job loss as machinery and automation replace human employees.

Fifteen per cent of companies surveyed plan to invest in some form of machinery to reduce dependency on human labour.

'These are jobs that once lost are unlikely to come back. That's been the history of automation. It marks an historic change in Southern African labour trends. This has always been a region with a surplus of human labour, where labour is cheap and workers are plentiful,' said the Swaziland Central Bank source.

Now, because of AIDS, a significant minority of companies are determining that the historically ample supply of regional labour may be shrinking or disappearing. Or else they can no longer afford to train workers who within a relatively short period of time prove to be temporary employees.

Company size has an influence on the access workers have to AIDS information. Most companies with more than 100 employees have AIDS programmes in place, compared to few programmes found at businesses with less than 100 employees.

— Inter Press Service

Nigerian economy to shrink by 20% due to HIV/AIDS

Constance Ndubuisi-Enyali

If current efforts to combat the effects of HIV/AIDS are not stepped up, Nigeria's economy will shrink by 20%, an expert has warned.

Health economist Dr. Reginald Chima made the submission at a session on the socio-economic impact of HIV/AIDS in Nigeria during the ongoing 4th National conference on HIV/AIDS in Nigeria.

After two decades of HIV devastation, Nigeria's economy will have lost 20% of her gross domestic product, he said.

'What this simply means is that if teachers are ill and unable to teach and if farmers are ill and unable to produce food, the quantity and quality of work done by the productive work force drops; therefore the overall income of the family and the community is greatly devastated.'

His presentation also examined the direct impact of HIV/AIDS on the family.

Ordinarily, food should not be a problem in oil-rich and fertile Nigeria, but with the steady depletion of farmers and other productive work forces by AIDS, food production in the country would certainly be threatened, Chima warned.

The Nigerian family faces reproductive, economic, political as well as socio-economic and cultural risks, due to HIV/AIDS, he pointed out, saying, 'What happens to the individual family is critical to how we perceive the impact of the disease. Whatever happens in the family rocks the community.'

There is also a need to understand that trends that fuel the spread of HIV originate from the family – men, women and young boys and girls – such that the vicious circle of sex, HIV and poverty becomes difficult to break, he noted.

According to Chima, who works with the Africa regional office of the UN Population Fund (UNFPA) based in Harare, the major question that Nigeria needs to find an urgent answer to is: 'Can we get people to go to the communities and families to address the many problems confronting the family – the men, women and vulnerable children who have suffered as a result of HIV and AIDS?'

UNESCO country director for Nigeria, Mr. Hubert Charles, said Chima's presentation captured the challenge that the HIV/AIDS pandemic poses.

'HIV/AIDS is the issue of the century. We must learn to become much more inclusive and to see the roles that others play to empower our own roles, to understand that we cannot do it alone – as NGOs, universities or governments,' he said.

— nigeria-aids.org

Constance Ndubuisi-Enyali is a correspondent for *Nigeria-AIDS eForum*.
Email: *constanz@nigeria-aids.org*

Business closes its eyes to the dangers of AIDS

Zarina Geloo

A report by international auditing company PricewaterhouseCoopers says Zambia's economy may lose about $50 million annually if the current rate of HIV infection continues unchecked.

According to the World Health Organisation (WHO), 20% of Zambian adults are infected with the HI-virus that causes AIDS.

Speaking at the launch of the report, Pricewaterhouse Chief Executive Richard Mazombwe said the WHO had established that when a fifth of the adults in a country were HIV-positive, then the gross domestic product of that state could be reduced by 1%.

'Translated into our (Zambian) economy, this means 225 billion kwacha ($50 million) will be lost annually. This is a colossal amount of money for a poor country like Zambia to lose, just because it has let a situation get out of control,' he told journalists.

Mazombwe said the survey was conducted in Zambia, Kenya, Tanzania and Uganda from July to September 2003, amongst companies that represented various sectors of the economy.

Researchers interviewed managers at 216 firms. Of these, only 88 organisations had estimated how much HIV/AIDS would cost them in terms of added healthcare costs, absenteeism, poor on-the-job performance and added recruitment costs.

Most companies had not tried to find out – either by direct inquiry or other interview methods – what percentage of their workforce was infected with HIV. Those who had investigated HIV incidence put it at less than 5%.

'This is hardly consistent with the WHO epidemiology figures, and one would expect the workplace profile to mirror the national profile,' Mazombwe said, adding, 'Our survey showed that ignoring HIV/AIDS is exactly what a majority of business in these countries (is) doing.'

Researchers also found that only 39% of the organisations surveyed had a formal policy in place for dealing with HIV/AIDS in the workplace. Eighty per cent of companies were aware of the need to avoid discriminating against HIV-positive people when hiring new employees. However, 20% still conducted mandatory HIV tests when recruiting.

The survey highlights areas where companies could play a bigger role in fighting the pandemic. These include establishing formal HIV/AIDS policies, setting up education programmes and analysing the costs of HIV.

A few firms have already taken the lead in this respect, notably Standard Chartered Bank Zambia, which employs about 400 people.

About 40 in-house counsellors provide assistance to people at Standard Chartered who are affected by HIV/AIDS. The bank also encourages staff who have the virus to plan for their future, by showing them ways of investing so that they can look after themselves and their families if they are forced to leave work.

Interestingly, the bank is quite clear about the fact that it is first and foremost a business, and that 'an employee will be discharged on medical grounds' if necessary.

The findings of the survey have been received with some apprehension by other sections of the business community.

Entrepreneur Michel Gondwe told IPS that small companies simply couldn't afford elaborate HIV/AIDS policies.

'This survey was conducted by a big organisation for big corporations. (How) is a small or burgeoning business like mine going to be able to pay for antiretrovirals for its employees?' he asked.

Gondwe currently employs 10 people on a hope and a prayer that they do not have the HI-virus. He believes that government should support the business community with tax incentives and rebates for hiring HIV-positive people.

Coercing companies to come up with medical schemes might not be in the interests of workers, Gondwe added. 'Employers...will hire people on a casual basis with no contracts. The people who will suffer, actually, are the ordinary workers.' — *IPS*

Africa Recovery

Life expectancy has been cut to 37 years as HIV/AIDS death toll has increased. This means $50 million lost yearly to Zambia's economy.

Unsafe injections spread HIV

Even as the WHO estimates that 7.5 billion injections are given each year with dirty needles, increasingly studies have highlighted the role of unsafe injection practices in the spread of HIV/AIDS in Africa. While promiscuity has been tirelessly played up as a risk factor in the disease, the fact that dirty needles have been played down undermines efforts to reverse the pandemic and ignores corporate culpability. *NANCE UPHAM* shares her view.

Africa Recovery

Dirty injections have been unchecked throughout the 20 years of HIV spread in Africa.

What if corporate policy contributed to the spread of AIDS in a catastrophic way over the past twenty years? Would the story be told, or wouldn't it be more convenient to blame Africans' promiscuous sex?

What if, in Africa, unsafe blood handling and especially re-use of 'single use' disposable syringes had contributed to the launch of HIV epidemics and their mass dissemination?

When sterilisable glass syringes were replaced with plastic disposable 'single-use' syringes, many drank champagne in corporate headquarters! At the time some specialists, even in industry, protested it might be a crime to sell so-called 'single-use' plastic items to poor countries who could never afford enough of an un-sterilisable product that would become a 'multiple-use' rapid dispenser of diseases!

But corporate policy makers loved it, so soon the UN organisations followed and went back and forth between advocating sterilisable glass syringes that could be boiled for sterilisation – and new plastic throwaways that float in water.

Imagine: remember your great great-grandma might have had one pair of stockings, and a couple of diapers for the new babe, but then industry hit upon the nylon stocking. Fantastic! Nylon breaks right away so to be a fashionable lady, you have to buy one pair a day. That's multiplying sales by 30 every month, by 365 a year, by 6,000 per lady over 20 years, and multiply that by millions of customers, you get billions and billions additional stockings sales! As for diapers, it is properly extravagant the number of trees that are cut every year so that babes can get new diapers several times a day...! Of course, it is a labour-saver for women, but imagine how filthy the idea of a throwaway paper diaper being re-used?

Corporate earnings in the business, however, would get a giant leap, from a few million to a multibillion-dollar multinational conglomerate! Every year, over 1.25 billion syringes are sold to the African continent.

Africa littered with dirty plastic needles, and since there are never enough of these 'single-use' needles, those dirty needles become 're-used'. And where are those 'disposables' placed when 80% of hospital and dispensaries don't have budget, training or manpower for proper waste management? They end up in the courtyard, bloody syringes sticking out on garbage dumps, where children play, where mothers cook for their loved ones when hospitalised...!

What can one catch from re-use of single-use syringes during vaccinations, or while coming into a dispensary for care? Well, there is malaria, of course, and a great variety of bacteria, and there are

viruses, and hepatitis, and then HIV!

As a matter of fact in countries as diverse as India or Egypt, the great majority of Hepatitis C infections numbering in the millions and millions are due to 'dirty syringes' from large-scale immunisation campaigns, according to the WHO literature itself.

In the 1980s and 1990s which country did not see severe cutbacks in the health budget because of 'structural adjustments'?

The WHO estimates (and they are very, very conservative) that people get an average of three injections per year. (But it could be six injections, or 12 or even 20 per person in Africa, according to studies). Therefore, Africa as a continent of 850 million does not purchase enough products to use a clean syringe for every injection by any stretch of the imagination. Africa is short by a billion a year. Even if a lot of dispensaries still used old glass equipments, that would still mean hundreds of millions of potentially contaminating injections per year.

Can you imagine several million 'dirty injections' per year in Africa in the era of HIV? Where would one find the highest concentration of full-blown AIDS patients (with high viral load, i.e. containing a very high quantity of infectious virus per millilitre of blood)? In healthcare settings!

What happens to the poor African child who goes to the hospital for malaria and gets a quinine injection with a dirty needle that was used on an AIDS patient before him?

Who cares? The international experts are quite busy, thank you, preparing showbiz to promote 'safe sex' on the continent. Therefore, the problem of unsafe injections spreading HIV is ... ignored!

And what if, concomitantly, under cost recovery, poor families had to check into dispensaries with their own syringes? Does anyone seriously believe that a syringe would not be shared by the whole family?

What if, when patients bring their own, they are dipped into a multidose vial? Again all patients will share each other's ailments.

As far back as 1967 the American Medical Association identified that 'single-use' was a re-usable device and called upon manufacturers to do something that would really be a one-time only. But big manufacturers on the drive to the billion dollars could not care. So 'single-use' remained an image for marketing, like 'the Big Mac'.

A recent study on 'unsafe injections' in the world by the WHO, said that up to 60% were unsafe in Asia and Eastern Europe (where big HIV epidemics are underway), and they said, 35% in Africa. Where did they get that scary but lower figure? Testimonies throughout the 1980s and 90s put the figure closer to 80% in Africa. Well, they would tell you, just some statistical average...

The *World Health Report 2003* reminded everyone that HIV is a bloodborne retrovirus, that is, a virus most efficiently transmitted by blood contact (and therefore less efficiently transmitted through sex).

A nationwide epidemiological survey of South Africa revealed 6% of all South African children aged two to 14 were contaminated with the AIDS virus! This is astounding for a so-called 'primarily sexually transmitted' disease. Nationwide, South African women are contaminated to the level of 11%. The South African experts have begun to investigate the story, and lo and behold, in Cape Town, the first investigation uncovered many cases of children who could only have been contaminated through health care!

As was documented by the studies done from Burkina Faso to Niger, from Zimbabwe to Botswana, from Tanzania to South Africa, dirty injections have taken place unchecked throughout the two decades of HIV spread. The time has come to stop that now and lay bare the criminal negligence!

HIV is a bloodborne retrovirus. 'Bloodborne' means that it is a type of virus primarily transmitted through blood: blood transfusion, bloody birth, bloody dental care, bloody surgery with dirty medical sharps, blood-tainted needles during health staff accidents or children playing in refuse.

If 'officially' all the HIV epidemics in America, in Europe, or in large Asian countries such as China, started with re-use of needles, via blood-needle sharing among IV drug users, how come it's officially 90% sexual transmission in Africa?

How come Africa is so special, that with at minimum 35% unsafe (i.e., dirty needle practices in health settings – WHO figures), collapsed health care and re-use of needles would only be responsible for 0.5% of all HIV cases? Who is kidding who? Whose corporate interests are being protected and whose financial institutions which engineered the past 20 years' collapse in health care are we protecting when we continue to blame HIV/AIDS on alleged African promiscuous sex?

In Africa, HIV rides on the chronic immune activation of people living in an environment where there is a lot of tuberculosis, malaria and intestinal worms. In short, high debt burden, macroeconomic policies detrimental to the subsistence of populations and associated unchecked common epidemics were the most favourable milieu for HIV.

Looking back retrospectively at the epidemic over 20 years, and looking at the astounding carelessness of international bodies over the fact of unsafe injections, one is left to wonder who slept with who in disease control? There is the foul smell of a public-private partnership...

We cannot commemorate Black chattel slavery and not face the real culprits for AIDS spread, a disease which will depopulate the continent. Rev. Samuel Kobia, General Secretary of the World Ecumenical Council, said: 'The time has come when HIV/AIDS should be equated to an enemy ... AIDS could depopulate Africa to an extent not seen since Slavery!'

The fundamental cause of the spread of AIDS is the same as slavery: abominable greed.

Nance Upham is President of the People's Health Movement-Geneva International.

Are UN troops spreading AIDS?

Michael Fleshman

Conflict brings economic and social dislocation, notes the Joint UN Programme on HIV/AIDS (UNAIDS), including the forced movement of refugees and internally displaced people and resulting loss of livelihoods, separation of families, collapse of health and education services, and dramatically increased instances of rape and prostitution. All this contributes to conditions for the rapid spread of HIV and other infectious diseases. Military personnel, too, risk contracting or spreading the fatal illness, whether deployed as belligerents or peacekeepers.

Africa Recovery

African armies and UN peacekeepers are grappling with how to halt the spread of AIDS within their ranks.

The degree to which conflict contributes to the spread of HIV remains uncertain. The conditions which increase the risk of HIV infection in war zones also make it difficult to collect accurate information about infection rates or identify patterns of transmission. The limited data available, however, is alarming. A study of Nigerian troops returning from peacekeeping operations in West Africa, for example, conducted by the non-governmental Civil-Military Alliance to Combat HIV/AIDS (CMA), found infection rates more than double that of the country overall. Significantly, the study also found that a soldier's risk of infection doubled for each year spent on deployment in conflict regions — suggesting a direct link between duty in the war zone and HIV transmission.

Part of the problem, DPKO Medical Unit head Dr. Christen Halle told *Africa Recovery*, is that conflict tends to bring together two groups at very high risk of HIV infection — commercial sex workers and 15-24-year-old men. 'Among refugees and displaced people it is common for the number of commercial sex workers to increase because women feel they have no other way to keep their families alive.'

A similarly risky dynamic, he said, occurs among soldiers. 'Military culture tends to exaggerate male behaviour,' he explained, by removing thousands of young men in their sexual prime from the behavioural constraints of family and community, inculcating a sense of risk-taking and invincibility, and promoting aggression and toughness as the male ideal — attitudes that extend to sexual behaviour and often lead to contact with commercial sex workers.

A study of Dutch soldiers on a five-month peacekeeping mission in Cambodia found that 45% had sexual contact with prostitutes or other members of the local population during their deployment. With 18 violent conflicts, tens of thousands of troops in the field and some eight million refugees and internally displaced people, Dr. Halle noted, it would be surprising if war were not a major factor in the spread of HIV in Africa. 'There is a whole context [in combat areas] which contributes to the spread of infectious diseases, including sexually transmitted diseases like HIV.'

High infection rates

The behaviour of the Dutch contingent in Cambodia lends statistical weight to a truism of

military life: that for as long as there have been wars and young men to fight them, soldiers have found opportunities for sex and, inevitably, for the transmission of sexually transmitted diseases. Until very recently such illnesses were considered among the least of a soldier's worries – often handled with 'a wink and a nod' by local commanders and a strong dose of antibiotics from the medics. But amid evidence that infection rates for the AIDS virus are soaring among African military and police personnel, African governments, the UN and the international community are taking a closer look at the link between the uniformed services and AIDS, and are expanding education and prevention programmes.

Even in peacetime, UNAIDS estimates, HIV rates are 2-5 times higher among soldiers than for the populace as a whole. During operational deployment in conflict areas, infection rates among military personnel can be as much as 50 times higher than among civilians back home. When CMA first began working with African military leaders in 1993 to develop HIV education and prevention programmes, said CMA Associate Director Dr. Rodger Yeager, the usual response was denial. 'For years we were told that AIDS was only a problem for homosexuals and drug addicts in the West,' he said. 'It was only when AIDS began to degrade readiness' – the ability of an army to put forces in the field with the training, manpower and equipment to accomplish its mission – 'that the high command stopped denying they had a problem and started asking "what can we do?"'

For soldiers and police already infected with HIV, the answer is very little. African militaries, like the states they defend, lack the resources to provide the afflicted with life-saving medications. Indeed, said Dr. Yeager, while almost all African militaries have adopted model 'best practice' policies to provide troops with voluntary testing and counselling, few can afford to actually provide such services. Nor is there any guarantee that individual soldiers would step forward for voluntary testing, given the stigma that still surrounds the disease in many countries and the danger of dismissal from the armed services if tested positive.

A few African countries already are beginning to focus some of their limited resources on HIV education for the military. In February, Burkina Faso's defence and health ministers met with the top armed forces officers to agree on a plan of action against HIV/AIDS in the military, as one component of the government's national anti-AIDS programme.

Dealing with the problem

The policies and attitudes of member states, particularly those of the major troop contributors, are central to the UN's own efforts to combat HIV among peacekeeping personnel. Troop-contributing states are responsible for the training and outfitting of the soldiers they make available to the UN, and DPKO can advise — but not dictate to — member states about their HIV/AIDS programmes. The issue has grown in significance amid concerns that the UN itself may be an unwitting agent for the spread of the virus around the world. 'I regret to say,' the former US Ambassador to the UN, Richard Holbrooke, told the Security Council in January 2000, 'that AIDS is being spread, among other people, by peacekeepers.'

While researchers agree that Mr. Holbrooke's statement is almost certainly true, a lack of data makes it impossible to accurately gauge the severity of the problem. Only a handful of cases have been publicly documented, and the most reliable way to measure the risk — mandatory testing of personnel before and after deployment abroad — is favoured by only a few countries.

The concern is justified: 'We are huge movers of young people across borders and between continents,' Dr. Halle noted. 'Some come from non-endemic countries for deployment in endemic areas. Others come from endemic countries to non-endemic areas. It is a huge concern of ours that the legacy of the UN not be that of bringing the virus into the local environment. The legacy to the country providing the peacekeepers should not be to have them bring the HIV virus back home.'

The principal objection to mandatory testing of peacekeepers, he explained, is on human rights grounds. 'We cannot force a person to take a test that would exclude him or her from their chosen profession. Until we have a guarantee from troop contributors that the soldier found HIV-positive will not be discriminated against, we will find it very hard to change the policy.'

Current DPKO policy as established by the General Assembly is to strongly encourage member states to offer voluntary and confidential counselling and testing (VCCT) to peacekeeping personnel, and encourage troop-contributing countries to strengthen HIV/AIDS education and prevention courses in national military training programmes.

One of the biggest obstacles to voluntary testing, however, is cost. 'Africans are the most vocal about the need for [voluntary] testing, but also that testing is expensive,' said Dr. Halle. 'They have the will to do it. They have the policy to do it. But they do not have the financial means to do it.' There has been some indication that industrialised countries are willing to underwrite the cost of VCCT by the UN, but even then, said Dr. Halle, there are serious human rights and ethical issues: 'It is important in a way that the results belong to us,' and not the soldier's government, he asserted. 'Because then we can oversee the way we use it so that the results are not used to discriminate.... The confidentiality issue is important here.' Like many of the issues surrounding HIV testing, however, there is no consensus among member states about UN testing of peacekeepers. Some countries have reportedly insisted in preliminary discussions that any future HIV test results be made available to the soldier's government.

Changing attitudes

For Dr. Halle, the real challenge of reducing HIV in UN ranks comes not from the difficulty of developing culturally appropriate training materials, but in changing the attitudes that lead to unsafe and unacceptable behaviour — particularly towards women and children. For that reason, Dr. Halle noted, DPKO's HIV/AIDS initiative is guided as much by Security Council Resolution 1325 emphasising the rights of women and children in conflict as it is by Resolution 1308 on HIV and conflict. Rape and prostitution are often seen as inevitable consequences of war, he observed, 'but they shouldn't be. These things should be no more tolerated in war than they are in peacetime.'

By changing attitudes, he said, DPKO hopes not just to change the behaviour of peacekeeping troops in the mission area, 'but to make them activists and advocates to stop the spread of HIV when they get back home. We are trying to develop responsible peacekeepers — responsible not only in the way they handle their weapons and their direct tasks as peacekeepers, but responsible also in the way of handling their relationship to the population in the mission area and back home.'

In the struggle to change attitudes, Dr. Halle said, the UN's greatest allies are the religious leaders who accompany their troops into the field. For all the differences in culture, policy and approach, he concluded, there is a standard of decency and behaviour common to all humanity. 'I do not expect a Muslim imam to promote the use of condoms. Nor do I expect a Catholic padre to do that. But what I have every right to expect, and where they do comply, is in talking about how you treat the people around you, especially the most vulnerable, the women and children. If you do that within the context of the Universal Declaration of Human Rights, within the context of global ethics, then you do something to contain the epidemic.'
— *Africa Recovery* (June 2001)

As EU expands, HIV and drugs a problem

Stefania Bianchi

The enlargement of the European Union could push the bloc into a 'major drug crisis', a leading international drug policy think-tank warns.

The Senlis Council, an international network that gathers expertise and facilitates new initiatives on drug policy, says two major challenges threaten an enlarged European Union (EU) — the possibility of a Europe-wide HIV epidemic, and increased pressure of trafficking from central and southern Asia.

'With the threat of HIV/AIDS seeping into Europe from the east, combined with high levels of trafficking, Europe could be on the verge of a major drug crisis in terms of consumption rates and public health,' the Senlis Council said.

The Council says that what could turn out to be the largest HIV/AIDS epidemic is currently spreading in Russia, Belarus and Ukraine, and could cross into the enlarged EU.

The World Health Organisation (WHO) estimated in February that the number of AIDS cases across eastern Europe and the Central Asian Republics has risen from 30,000 in 1995 to 1.5 million in 2004, a 50-fold increase in eight years.

The Senlis Council says high infection levels within the injecting drug user community are gradually spreading into the wider population, and fears that if the trend continues infection rates may overtake those in Africa.

WHO says that the numbers of HIV cases in this region are still small compared to an estimated 40 million cases worldwide, with about 27 million in sub-Saharan Africa, but it is concerned that HIV cases are rising rapidly.

EU countries have already started to see 'the consequences of their proximity with alarmingly high HIV/AIDS prevalence in Estonia, and to a slightly lesser degree in the other two Baltic States, Latvia and Lithuania, who share a frontier with Russia,' the Council says.

'Free movement of citizens within the enlarged EU could transmit infection brought into the border countries from Russia, Belarus or Ukraine,' said Jane Francis from the Senlis Council.

'To avoid this, prevention measures must be taken not only within the EU where policy is relatively advanced and measures have been taken to try and control the spread of HIV in terms of drug policy, but also in partnership with these neighbouring countries, to avoid the trans-frontier spread of infection and to cut the threat at the root in its country of origin,' she added.

The Council is also concerned that drugs may penetrate the EU's enlarged borders. It says as Europe moves further east, it also moves nearer the 'Balkan route' — the traditional drug trafficking route which leads from central and south Asia into Europe.

'Pressure from drug trafficking from Asia, which comprises many traditional production countries, bears down on Europe's new frontiers,' the Council, said in its report. 'An abundant supply of heroin from Afghanistan, the world's largest producer of opium, is a major threat to the new Europe.'

There are concerns also for

An abundant supply of heroin from Central and Southern Asia threatens the new enlarged Europe and poses the danger of HIV/AIDS spreading across the EU. Picture on left shows a field of opium poppies from which heroin is processed.

countries outside of the EU. 'Drug money is on the verge of destroying the recent efforts to stabilise Afghanistan,' Emmanuel Reinert, executive director of the Council, said in a statement. 'The risk of corruption and of drug lords ruling the country potentially makes Afghanistan the "Colombia of Europe".'

EU drug policy required

The Senlis Council is calling on the EU of 25 to 'reinforce and strengthen their commitment to the innovative and evidence-based drug policy measures and responses which have proved efficient in many member states'. It is also urging prevention, education and regulation efforts on consumption based on the recent success in many European countries of curbing the tobacco epidemic.

'Enlargement is a unique opportunity for Europe to illustrate to the international community that pragmatic and realistic policies should take precedence over the purely repressive "war on drugs"-orientated policies which have been failing over the past 40 years,' it said.

'The American "war on drugs" has no place in Europe,' it added. 'Europe needs to use its now even larger weight to prove to other parts of the world that the focus of global drug policy must be on solutions and not on war.'

The European Commission, the EU executive, says EU enlargement presents the bloc with 'both new challenges and opportunities' on the drugs front. 'We cannot ignore the concern that enlargement will lead to an increase in drug trafficking from and through the central and eastern European countries,' Antonio Vitorino, EU commissioner for justice and home affairs, said at a conference in February on 'European Drug Policy on the Brink of Change'.

'Some of the new member states have traditionally been transit countries for drugs destined for the EU,' he said. 'Large-scale drug seizures, especially of heroin, on the Balkans and central European routes confirm that trafficking continues and that drugs are stored in those areas. But we should also bear in mind that the enlargement will provide us with the opportunity to cooperate more closely to tackle the problem.'

The Commission says that the new member states need 'all the support available' to ensure that drugs will remain a policy priority in a situation 'where action against drugs has to compete for resources with many other priorities'.

It adds that a 'major tool in the fight against drug trafficking' is an EU action plan on drugs. All 25 EU member states have committed themselves to the goals of the plan, which provides a guide to setting priorities in the drugs area. While the plan is not a legally binding document, the Commission says it provides a 'strong incentive' for all actors involved to reach the agreed targets.

The Senlis Council says the plan is mainly a coordinating device that works as a framework agreement. 'Apart from this action plan, there is no single EU drug policy and no single EU position on many issues involving drugs and drug-related diseases,' Francis said. 'Therefore, on a practical level, the EU could do many things to strengthen its common position and convert it in a common policy.'

– Inter Press Service

Ten per cent of AIDS patients resistant to drugs

The biggest study so far of resistance to AIDS drugs, released at a July 2003 international AIDS conference in Paris, finds that about 10% of all newly infected patients in Europe have drug-resistant strains.

That has worldwide public health implications, because it suggests that many AIDS patients who are in treatment return to engaging in high-risk sex or needle-sharing.

It also shows that new drugs must be aggressively sought and that an 'order of battle' approach to prescribing them, like that used for tuberculosis drugs, should be adopted in place of the current free-for-all.

For example, a drug like nevirapine, which can prevent mother-child transmission with just one dose, may be segregated for that use only so that resistance to it cannot grow as it would if thousands of patients were put on it for life.

But AIDS experts emphasised that the possibility of creating resistance was not a reason to deny drugs to the poor.

The study tested 1,633 patients from 17 European countries in whom infection with the AIDS virus had just been diagnosed and who had not yet been treated for it. (It is nicknamed the Catch study for 'combined analysis of resistance transmission over time of chronically and acute infected HIV patients in Europe'.)

About 9.6% of the patients were resistant to at least one of the three types of anti-retroviral drugs that suppress the AIDS virus. There are 17 such drugs, but they all fall into one of three classes: nucleoside reverse-transcriptase inhibitors, non-nucleoside reverse-transcriptase inhibitors and protease inhibitors. Normally, a patient takes a 'triple therapy cocktail' of all three to attack the virus at three sites.

Resistance to the first group was found in 6.9% of those studied, resistance to the second was found in 2.6%, and resistance to protease inhibitors was found in 2.2%.

Two new classes of drugs, fusion inhibitors and integrase inhibitors, are in testing stages, so resistance is presumed not to exist yet.

No similarly large study has ever been done in Africa. In sub-Saharan Africa, where 2.4 million people died of AIDS in 2002, only about 50,000 are getting anti-retroviral drugs, according to the United Nations.

In the Catch study, resistance was much higher, at 11.3%, among Europeans who had subtype B human immunodeficiency virus, compared with those with non-B subtypes, in whom it was 3.3% .

B is the subtype infecting 98% of Americans and about 60% of Europeans. It is the subtype that has spread most widely since AIDS was discovered in Los Angeles, San Francisco and New York in the early 1980s.

Though subtype B originally came from central Africa, subtype A, C and so on prevail in other parts of Africa and in Asia.

— *International Herald Tribune*, 17 July 2003

HIV superinfection increasing, say docs

Evidence is growing that 'superinfection' with more than one strain of HIV may be more common than previously thought, which could complicate efforts to make a vaccine, experts said at an international AIDS conference.

Scientists reported three new cases of HIV-infected people who were doing well without drugs but became sick years later after contracting a second strain of the AIDS virus.

'That means that although you can mount an adequate response against one virus, the body still does not have the capability to protect you against new infection, which tells you that the development of a vaccine is going to be even more of a challenge,' said Dr Anthony Fauci, director of the US National Institute of Allergy and Infectious Diseases.

None of the patients in the three cases were being treated for HIV, which can become resistant to drugs over time.

Dr.Luc Perrin, from the University of Geneva, in a study followed 136 drug users with HIV and found that the amount of HIV in the blood of five patients suddenly shot up after years of control without drugs. Tests confirmed that two of the five had a superinfection.

In another study, Dr Harold Burger of Albany Medical College said genetic tests on a superinfected woman showed the two viruses mixed and produced a hybrid that took over from the original virus.

Scientists estimate there are 14 mixed strains circulating – the report is the first documented case of two HIV strains, or subtypes, combining in one person to form a third strain.

Surveys of HIV patients have found many mixtures of virus strains. Scientists suspect they occur when two viruses mix in the bloodstream, but this is the first time they've proven it can happen that way.

– *AP* in *The Star* (Malaysia), 16 July 2003

Drug-resistant HIV strains fight back

HIV is fighting back. Drug-resistant strains now account for a tenth of new infections in North America, and the proportion is rising rapidly.

Although almost all patients with these resistant strains respond to antiviral drug cocktails, they respond more slowly, emphasising the need to develop new drugs to combat resistance.

Antiviral drugs are the only effective weapon against AIDS. But this success hasn't been unqualified. The vast majority of HIV-positive people cannot afford the treatment, and those who take them often suffer unpleasant side effects. To make things worse, drug-resistant strains of HIV are becoming more common around the world. A study released in 2001 found that more than three quarters of people being treated for HIV have resistant strains.

The latest study looked at 377 people in Canada and the US who had recently been infected with HIV, and had not yet started drug treatment. The team tested viruses from patients for resistance to 15 different HIV drugs, all of which target one of two enzymes.

In samples collected between 1995 and 1998, only 3% of patients harboured resistant viruses, a third of which were resistant to two or more drugs. But over the next two years, the proportion jumped dramatically: 12% were resistant, half of which were resistant to more than one drug (*New England Journal of Medicine*, vol 347, p385).

'This study shows why you can never be developing drugs fast enough against HIV or any microbe you can't eradicate,' says Anthony Fauci, director of the US National Institute of Allergy and Infectious Diseases. — *New Scientist,* 17 August 2002

Patients who drop treatment pose risk drug-resistant HIV strains may spread

One in five AIDS patients receiving free antiretroviral drugs from the Chinese government abandoned the 'drug cocktail' during the first seven months of the programme, raising the risk that drug-resistant strains of the AIDS virus might emerge and spread across China and then the world.

Several researchers said if the government continues distributing drugs without putting in place a network of trained counsellors and medical personnel to administer them, patients could continue dropping out of treatment and drug-resistant strains of HIV could emerge and exacerbate the crisis.

Zhang Fujie, director of treatment for China's national AIDS control centre, said more than 1,040 of the 5,289 patients receiving free drugs have discontinued treatment. He said still others may have stopped taking the drugs without notifying the government or may be taking the drugs only occasionally.

Mr.Zhang attributed the high dropout rate to the severe side effects caused by the drugs, and blamed both the limited mix of low-cost drugs available in China and a shortage of qualified medical staff who can monitor patients and fine-tune treatment to manage side effects.

'We have a lot of problems and difficulties,' Mr. Zhang said, adding that fewer than 100 doctors in China have experience treating AIDS.

One problem China faces is the limited selection of antiretroviral drugs available at low cost.

— *Asian Wall Street Journal*, 11 November 2003

Drug-resistant TB surge

With multidrug-resistant tuberculosis (MDR-TB) striking parts of Eastern Europe and Central Asia 10 times more heavily than elsewhere in the world, WHO has called for increased action and resources to control the disease, which kills one quarter of the 8 million people infected globally each year.

'TB drug resistance is an urgent public health issue for countries from the former Soviet Union,' the Director of the Geneva-based WHO's Stop TB Department, Mario Raviglione, said. 'It is in the interest of every country to support rapid scale-up of TB control if we are to overcome MDR-TB.'

A new report* confirms geographical concentrations of TB drug resistance across the Commonwealth of Independent States. Six out of the top 10 global hotspots are Estonia, Kazakhstan, Latvia, Lithuania, parts of the Russian Federation and Uzbekistan, with drug resistance in new patients as high as 14 per cent. China, Ecuador, Israel and South Africa are also identified as key areas.

WHO's leading infectious disease experts estimate there are 300,000 new cases per year of MDR-TB worldwide. New evidence proves that drug-resistant strains are becoming more intractable and unresponsive to current treatments, with 79% of MDR-TB cases classified as 'super strains' resistant to at least three of the four main drugs used to cure TB.

Resistant to the two most commonly used medicines, Isoniazid and Rifampicin, MDR-TB – without costly interventions – is untreatable and in most cases fatal. Though curing normal TB is cheap and effective – a six-month course of medicines costs $10 – treating MDR-TB is 100 times more expensive, according to WHO. Even then a cure is not guaranteed. With no effective vaccine, everyone is vulnerable to infection simply by breathing in a droplet.

The report says 'the most effective strategy to prevent the emergence of drug resistance is through implementation of the DOTS' — the internationally agreed treatment strategy designed to ensure patients take their medicines properly. It has proven effective in preventing drug resistance.

The highest prevalence of MDR-TB coincides with one of the world's fastest-growing HIV infection rates in Eastern Europe and Central Asia. Recently the UNDP reported there are more than 1.5 million people with the virus in the region, compared to just 30,000 in 1995. People whose immune systems are compromised with HIV are highly susceptible to contracting all forms of TB.

— *PHA Exchange* electronic mailing list
[<http://www.who.int/gtb/>]*

AIDS: Struggle for human rights in Africa

Joy Ngozi Ezeilo

There have been a number of litigations in Africa on the human rights of people living with or affected by HIV/AIDS. Issues of confidentiality, informed consent for testing, discrimination in employment and access to drugs and treatment have been subjects of serious contestation in our law courts. This article examines how litigation can help promote and protect the rights of people living with HIV and AIDS (PLWHAs) as well as fight HIV/AIDS stigma. While many factors constrain PLWHAs from benefiting from litigation, the critical obstacle is the non-recognition of their rights. The author proposes the institutionalisation of human rights education on HIV/AIDS along with legal reforms to reduce discrimination against PLWHAs.

Africa Recovery

HIV/AIDS sufferers face stigma and discrimination everywhere. They are denied the right to healthcare and treatment.

Some of the greatest challenges in the campaign against AIDS involve stigma and discrimination. These create important barriers to prevention and treatment efforts. The stigma and discrimination faced by PLWHAs make many people afraid of being tested or of seeking assistance if they know they are infected.

In fact HIV/AIDS is an epidemic of stigma and discrimination. Stigma affects not only the lives of PLWHAs but also those of their lovers, families and caregivers. It affects not only those who are stigmatised but also those in the community, on the job, in professional capacities, in public office or in the media who stigmatise them. Often the stigma of HIV/AIDS compounds old prejudices with new ones.

As a result of stigma Africa's growing number of PLWHAs encounter many human rights problems regarding confidentiality, informed consent for HIV/AIDS testing, discrimination in employment and health services and access to drugs and treatments. PLWAS in most parts of Africa have been forced to suffer extreme discrimination in silence. The main reason is fear of stigmatisation.

In addition litigation in general is not an easy affair in Africa. Culturally most Africans are litigation-shy and will only go to court as a last resort. Other factors also constrain litigation. The most important is legal non-recognition of rights.

Human rights and public health

The HIV/AIDS pandemic has raised many issues worldwide about the human rights both of people living with HIV/AIDS and of people affected by HIV/AIDS (PABA). The most prominent of these issues is the right to equality of treatment and freedom from discrimination. The discriminatory treatment meted out to many PLWHAs has been justified on the basis of separating the healthy from the infected for the protection of society according to the notion of the common good.

Is a medical officer who discriminates against a patient with HIV/AIDS on this notion of public health acting legally? What amounts to protection of public health? In the bills of rights of national constitutions restrictions of fundamental human rights are often justified on grounds of public health, safety or morality. However the concept of the public good is an unruly horse, and it is often difficult to determine what should be included within the concept.

The WHO/USAIDS International Guidelines on HIV/AIDS and Human Rights recommend that states review and reform public health laws to ensure that the laws adequately address public health issues raised by HIV/AIDS and that their provisions on easily transmitted diseases are not inappropriately applied to HIV/ AIDS, which is relatively difficult to transmit.

The rationale for this is that protecting HIV-related human rights will not impede the achievement of public health goals as long as appropriate steps are taken. The guidelines also advise states to strengthen their public education efforts against the stigmatisation and discrimination.

Therefore public health laws are expected to empower public health authorities to provide a comprehensive range of services for the prevention and treatment of HIV/AIDS, including relevant information and education, adequate sexual and reproductive health services (including provision of condoms), access to voluntary testing and counselling and appropriate HIV/AIDS drug treatments, as well as adequate treatment for HIV/AIDS-related illnesses.

In particular the public health argument should not be used to victimise PLWHAs by subjecting them to isolation, detention or quarantine on the basis of their HIV status. In fact, the stigmatisation of PLWHAs is actually detrimental to public health. By contrast an environment in which their human rights are respected ensures that vulnerability to the disease is reduced. By enabling PLWHAs and PABAs to live in dignity and equality both the personal and societal impacts of HIV infection are alleviated.

In the name of public health

In Africa, people with HIV/AIDS continue to suffer discrimination. Their rights to privacy and confidentiality are breached with impunity. They are tested for HIV without their consent and without pre-test or post-test counselling. For vulnerable groups such as pregnant women this can expose them to violence from their spouses and stigmatisation from their communities.

The justification usually put forward is protection of health-care providers and other health users. But could not the same public health argument be used to test service providers for HIV? Is it not equally in the interest of public health that the status of health-care providers is known?

Lessons learned

A number of lessons can be learned from a brief survey of HIV/AIDS-related human rights cases. One lesson is that PLWHAs in Africa experience heavy stigmatisation, discrimination and other human rights violations with little hope of redress through the courts (see box story on Nigeria) . This situation is a major factor driving the HIV/AIDS pandemic, as it creates powerful disincentives to disclose one's HIV status or to seek treatment, thereby increasing the chances of further transmission of the infection.

A second lesson is that the law is being underutilised to confront stigma and assert the human rights of PLWHAS. Successful cases in South Africa (see box on South Africa) show that the human rights of PLWHAs can be legally protected. However it is also clear that many PLWHAs in Africa do not understand their rights and fail to respond appropriately when their rights are violated.

Nevertheless the law is not a panacea. It can create an enabling environment but it cannot legislate people's behaviour. It can only try to redress the consequences of behaviour when it violates others' rights. Furthermore litigation may create or worsen rather than alleviate stigma in individual cases. At a wider level, however, it increases people's understanding of HIV and of the rights of PLWHAs. Thus class action suits may be preferable in many circumstances. However in Africa lack of resources makes many social and economic rights such as the right to access to treatment difficult if not impossible to enforce even through class action.

Recommendations

In the end the key question is: how do we get appropriate information on AIDS prevention and care skills to the people who need it, fight HIV/AIDS stigma and discrimination and create a social consensus on safer behaviour? Research has shown that any approach to preventing HIV infection that fails to take human rights into account will be ineffective and unsustainable. With this in mind I offer the following observations and recommendations.

♦ From the experience of countries that have attempted it, it is clear that the criminalisation of intentional transmission of HIV impedes prevention and control. For the real protection of the public's health, criminal and anti-discrimination legislation should prohibit mandatory HIV testing of target groups.

Informed consent and counselling must always precede such testing. Participation in HIV clinical trials should be voluntary as well as confidential. The government must not shy away from its obligation to provide treatment without discrimination to infected persons as well as support services for persons affected by HIV/AIDS.

♦ Efforts must be increased to create awareness at community level through human rights education that promotes understanding of HIV and the rights of PLWHAs and reduces HIV/AIDS stigma.

♦ Legal reforms and legal advocacy can be effective in reducing stigma when integrated with other community interventions.

♦ Healthcare workers should receive training in ethics and human rights before being licensed to practise and should be retrained regularly. There is no doubt that health workers take enormous risks caring for infected persons. However this does not justify discriminatory practices. A code of conduct based on human rights and covering specific HIV/AIDS-related issues should therefore be adopted and enforced in all public health facilities.

♦ International regulations on HIV/AIDS should be made binding at international and domestic levels. In particular fair and equal access to treatment for PLWHAs should be guaranteed. This will enhance prevention, openness and non-discrimination. We must promote and respect individual autonomy and dignity in the provision of HIV/AIDS treatment.

♦ Policies on HIV/AIDS should be translated into laws to create binding legal obligations at the national level. The law should allow PLWHAs to bring actions under pseudonyms, prohibit disclosure of identity and permit

hearings in camera to protect the privacy of PLWHAs and encourage them to seek legal redress when their rights are violated.

♦ Free legal aid services should be made available to PLWHAs whose rights have been violated, and cases involving the rights of PLWHAs should receive accelerated hearings. Justice delayed is justice denied.

♦ Intergovernmental agencies and donors should fund programmes and projects, particularly legal outreach education at grassroots levels, focusing on the human rights dimensions of HIV/AIDS.

The few cases reviewed in Africa have shown that while litigation has promoted protection of rights, particularly the right to freedom from discrimination and the right to informed consent, it has yet to assist in destigmatisation. Stigma remains a critical issue in deciding whether to litigate or not. Consequently many PLWHAs whose rights have been violated avoid the courts, even when free legal aid is available.

As a result many PLWHAs have suffered extreme discrimination in silence. Many have lost their jobs following mandatory testing imposed by employers but have not sought redress in the courts. However as long as we allow abuses of the rights of PLWHAs, our efforts at prevention of HIV infection and management of the HIV/AIDS pandemic will be seriously marred.

What is most critical is education and counselling of the most vulnerable groups, such as drug abusers, sex workers and prisoners. Condoms, bleach and clean needles must be made available. Moreover in most parts of Africa the law as it stands punishes people for prostitution and homosexuality. We urgently need to review these laws, decriminalise these behaviours and make new laws to protect health workers and their clients.

Joy Ngozi Ezeilo is with the Department of Public and Private Law, University of Nigeria. She is also the Executive Director of the Women's Aid Collective (WACOL) Enugu State, Nigeria.

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Nigeria: The right to work

On 14 July 2000, the Social and Economic Rights Action Centre (SERAC) filed Nigeria's first-ever HIV/AIDS discrimination lawsuit (Mrs Georgiana Ahamefule v. Imperial Medical Centre and Dr. Alex K. Molokwu, Suit No: ID/1627/2000, Unreported, Lagos High Court) challenging *inter alia* the termination of Mrs Ahamefule's employment at the Imperial Medical Centre because she was HIV-positive. The plaintiff had been employed as an auxiliary nurse at the centre. In 1995 she became pregnant and developed some boils on her skin, whereupon she sought medical attention from the second defendant, who was also Chief Medical Director at the centre.

Dr. Molukwu carried out some tests on the plaintiff without disclosing the nature or results, then asked the plaintiff to proceed on a two-week medical leave and referred her (with a note in a sealed envelope) to a Dr. Okany at Lagos University Teaching Hospital (LUTH). Upon reading the note Dr. Okany requested the plaintiff to come back with her husband, whereupon blood samples were taken from both without any reason being given. On Mrs. Ahamefule's next visit Dr. Okany infomed her that she had tested positive for HIV and that her husband had tested negative.

When Mrs Ahamefule returned to work after her medical leave, Dr. Molukwu abruptly terminated her employment without adequate severance compensation and despite five years of satisfactory service at the clinic. The letter of termination gave her HIV-positive status as the grounds for termination. In lieu of severance pay Mrs. Ahamefule received a letter of recommendation to assist her to get employment in another clinic. Soon after this the plaintiff had a miscarriage. Dr. Molukwu refused to carry out the recommended clean-up operation to remove the remains of the dead foetus. He based his refusal on Mrs. Ahamefule's HIV status, stating that he did not want to contaminate his instruments.

Mrs. Ahamefule then instituted an action against the clinic and Dr. Molukwu before the High Court of Lagos. She claimed:

♦ that the termination of her employment based on her HIV status constituted unlawful discrimination pursuant to Articles 2, 18 (3) and 28 of the African Charter on Human and Peoples' Rights (Ratification and Enforcement) Act;

♦ that subjecting her to HIV testing without her informed consent constituted unlawful battery;

♦ that the defendants' failure to provide pre-test and post-test counselling constituted professional negligence; and

♦ that the defendants' denial of medical care on grounds of her HIV status violated her right to health pursuant to article 16 of the African Charter on Human and People's Rights (Ratification and Enforcement) Act, Cap 10 of the laws of Nigeria and Article 12 of the International Convention on Economic, Social and Cultural Rights (ratified by Nigeria in 1993).

Mrs Ahamefule asked for five million *naira* general damages for wrongful termination of employment, three million *naira* as compensation for HIV testing without her consent and for the defendants' negligence and two million *naira* positive damages for the defendants' invidious actions. In their defence the defendants claimed that they terminated the plaintiff's appointment in the interest of public safety. They argued that [t]hey are statutorily bound to ensure that the hospital is safe, [and] that members of the public are safe, [and] protected from contagious or infectious diseases. They further stated that they have an obligation to protect the public at

large from being infected by HIV and that they had no regrets for terminating the plaintiff's appointment, as she was a danger to the community at large and to patients in particular. They then contended that Mrs Ahamefule should not be allowed to give evidence in court unless a medical report from an expert guaranteed that she would not infect others in the courtroom. Counsel for Mrs Ahamefule retorted that it was the plaintiff's right to give evidence in court and that in any case there was no other option. The judge ruled in favour of the counsel for the defendants, stating that life has no duplicate and must be guarded jealously.

Mrs Ahamefule's counsel then filed a notice of appeal in the Court of Appeal, contending that:

- the judge had erred in law by disregarding section 36(1) of the 1999 constitution which guarantees a plaintiff's or appellant's unrestricted physical access to the court;
- the judge's ruling violated Mrs Ahamefule's right to the dignity of the human person as protected by Section 34(1) (a) of the constitution.

Counsel urged the Court of Appeal to order a declaration:

South Africa: The right to medical treatment

A landmark case in South Africa was Treatment Action Campaign and two others v. Minister of Health and nine others in 2001 (Case No. 21182/2001). In this case the applicants instituted a class action against ten respondents: the Minister of Health and the MECs (Members of the Executive Council) responsible for health in the nine South African provinces.

The plaintiffs asked for a declaratory order that the respondents were obliged to provide nevirapine to pregnant women with HIV whenever it was medically indicated. They also asked for an order directing the state to produce and implement an effective national programme to prevent or reduce mother-to-child transmission (MTCT) of HIV, including the provision of voluntary counselling and testing (VCT), and, where appropriate, nevirapine or other appropriate medicines as well as infant formula.

The background to this case is the stark reality that about 29% of pregnant women in South Africa are HIV-positive and that about 70,000 or more children are infected each year through MTCT. Indeed MTCT is one of the commonest forms of infection in a country where five million of the total population, estimated at 40 million, are infected.

The Treatment Action Campaign (TAC) based their case on the South African constitution, in particular Section 27, which recognises the right of everyone to have access to healthcare services, including reproductive health care, and the state's obligations to take reasonable measures to ensure the progressive realisation of that right. The TAC argued that these provisions of the constitution obligated the respondents to provide nevirapine to pregnant women.

Before this case was instituted the respondents had agreed to make nevirapine available at only a limited number of pilot sites. These sites would have served only about 10% of the eligible population. Moroever in July 2000 the manufacturer of nevirapine, Boehringer Ingelheim, had offered to supply nevirapine to public health institutions in South Africa free of charge for five years. The respondents had not accepted this offer, although they were still discussing it.

When the TAC case came to court the respondents argued that they were not in breach of the constitution. They contended that all reasonable steps had been taken, given available resources, to achieve the progressive realisation of the right to health care. Furthermore they charged that the applicants were ignoring important infrastructural and operational considerations, such as the need to provide voluntary counselling and testing and to monitor the progress of everyone treated with nevirapine.

To make nevirapine immediately available at all public health facilities, they claimed, was impossible due to a lack of human resources. They also argued that making nevirapine available to everyone who needed it would have unsustainable cost implications which would compromise the state's ability to provide health care for other citizens. Finally they contended that nevirapine had not been adequately tested.

Nevertheless the High Court ruled in favour of the TAC. It ordered the respondents to develop and implement an effective, comprehensive national programme to prevent or reduce mother-to-child transmission of HIV, including the provision of nevirapine or other appropriate medicine and formula milk for feeding. The state immediately appealed to the Constitutional Court, arguing that the ruling interfered unacceptably with policy-making by the executive branch of government. However on 5 July 2002 the Constitutional Court reaffirmed the High Court's ruling.

This case has substantially advanced the general right of PLWHAs to access to treatment. Access to nevirapine and other AZT-based treatments will greatly reduce infant deaths due to MTCT, as well as the stigmatisation of HIV mothers who transmit the disease to their babies. In a cultural milieu where enormous value is placed on motherhood, it is a terrible burden for HIV-positive mothers to know that they have infected their babies. This is one of the major reasons why HIV-positive women conceal their status.

The TAC case – the culmination of almost four years of intense lobbying and public mobilisation – also came to symbolise the failure of the South African government to deal decisively with the HIV/AIDS epidemic. However the case also made clear the strength of the South African legal regime and constitution, especially in comparison to the rest of the continent.

Most other African states are yet to come to terms with the role of law and human rights in the HIV/AIDS pandemic. In Nigeria the 2001 HIV/AIDS Emergency Action Plan did not even mention respect for the human rights of PLWHAs in its 16 guiding principles. Uganda, cited by many as an example of how an aggressive state-coordinated campaign can help combat HIV/AIDS, still has no specific laws protecting the rights of PLWHAS. Not surprisingly recent research by UNAIDS shows a high prevalence of HIV/AIDS-related discrimination, stigmatisation and denial despite high levels of HIV/AIDS awareness.

In many African countries pregnant women are mandatorily tested without any intention to provide them with the necessary drugs to prevent MTCT. If the state requires pregnant women to be tested, should it not be required for its part to provide treatment to women found to be HIV-positive? Without such a policy, it could be argued, mandatory testing is effectively a form of torture or inhuman and degrading treatment. – *Joy Ngozi Ezeilo*, *CODESRIA Bulletin*, Special Issue 2,3 & 4, 2003

- that the plaintiff was a person as defined by the constitution and was therefore entitled to the enjoyment of her fundamental human rights irrespective of her HIV status;
- that restricting Mrs Ahamefule's access to the court was unconstitutional as it violated her rights to a fair hearing, to dignity of the human person and to freedom from discrimination.

The Ahamefule case is very important because of the media attention it attracted. It put the issue of the rights of PLWHAs at the centre of national discourse.

Two journalists, Gbolahan Gbadamosi of the *Guardian* and Jenny Ekukunbor of the *Vanguard*, were ordered to show cause why they should not be sent to prison for contempt of court for reporting the ruling denying Mrs Ahamefule access to the court. Ekukunbor subsequently wrote a retraction, which was published in three editions of the newspaper as ordered by the court, but Gbadamosi challenged the court's jurisdiction.

However, before his case could be heard, the contempt charges were not only struck out but so was the entire suit. The ruling cited undue publicity and the interest of the sick.

This was done notwithstanding that a valid notice of appeal had been filed challenging the court's previous orders and that applications for a stay of execution of the order denying the plaintiff access to court and for a stay of proceedings were also before the court. Moreover SERAC, the non-governmental organisation that acted on behalf of Mrs Ahamefule, alleged that the judge stonewalled the plaintiff's access to official records and to certified copies of court orders. The case file was withheld by the judge and only released to the records department after SERAC petitioned the Chief Judge of Lagos State and threatened to file for an order compelling the release of the file.

The Ahamefule case has garnered global attention because of its far-reaching public interest dimensions. The case has raised some burning human rights and ethical issues regarding HIV/AIDS and has also illuminated the intersection between law, human rights and public health. It points up the enormity of the tasks that must be accomplished if Nigeria is to tackle HIV/AIDS.

If a learned judge of the High Court can be so profoundly ignorant as to use coercive instruments of the state to suppress criticism of her flawed ruling, then the attitudes that must prevail at other levels of society are perhaps better left to the imagination.

Many people living with HIV have suffered persecution, rejection, stigmatisation and neglect in silence and without the law coming to their aid. Often the potential litigant is too ashamed to seek legal redress either because of fear of even worse consequences or because he or she simply does not know how to seek legal redress.

— **Joy Ngozi Ezeilo**, *CODESRIA Bulletin*, Special Issue 2, 3 & 4, 2003

Kenya: AIDS discrimination in schools

Joyce Mulama

A decision by the guardians of 72 HIV-positive children to sue Kenya's government for alleged discrimination in public schools appears to have struck a nerve in the East African country. AIDS organisations say this trend may be widespread, and they are calling on government to take action in the matter.

In January, a suit was filed on behalf of the children alleging they had been refused admission by five public schools, apparently because they were infected with the AIDS virus. The schools in question were located near Nyumbani Children's Home outside of Nairobi, where the children live. This institution cares for HIV-positive children who have been abandoned.

According to the home's founder, Angelo D'Agostino, the children had needed to register for the first school term of 2004, which started on 5 January.

Carol Olwana, director of an anti-AIDS lobby group in Nairobi, Campaigners for an AIDS Free Society (CAFS), wasn't surprised by the developments.

'This is something that has been happening for so long. It is only that it has never been exposed,' she says.

The Association of People Living With Aids in Kenya (TAPWAK) is equally concerned. 'The issue of public schools locking out children who are HIV/AIDS-positive is senseless. The government may not be directly involved. It could be a few individuals in the schools who lack information on the disease,' Rowlands Lenya, Executive Director of TAPWAK, told IPS.

The lawyer for the Nyumbani children, Ababu Namwamba, accused school principals, the City Council Education Department and the Ministry of Education of discriminating against his clients by refusing to enrol them. The government denied the charges.

The two parties have now reached an agreement in which the children will be admitted to various primary schools, with the City Council supervising the enrolment.

'We have reached consent with the government that the children be taken into class immediately,' Namwamba said. In a statement issued later, he added: 'Our judiciary has demonstrated its readiness to uphold and assert human entitlements of all shades, including those within the socio-economic realm, as being due to all classes of the citizenry, no less the vulnerable, the weak and the voiceless.'

Despite having settled matters with the children's home, the government is clearly nettled by the suit. 'We have agreed. But (Nyumbani) wants to paint a bad picture of the government,' said John Gacivih, Deputy Chief State Counsel for the Education Ministry.

Teachers, in their turn, claim to be bewildered by the outcry about alleged discrimination.

'We are not aware of anything of that sort as a union. We have never received any complaints from anybody. We just read it in the newspapers', Lawrence Majali, acting Secretary-General of the Kenya National Union of Teachers, said.

Free primary education in Kenya was introduced early last year after the government of President Mwai Kibaki took over power on 31 December 2002.

In September last year, the government also introduced the 'HIV and AIDS Prevention and Control Bill' which, amongst other things, seeks to criminalise discrimination against people living with HIV/AIDS. – *Inter Press Service*

Nigeria: Rights activist seeks to end discrimination

Femi Soyinka, one of Nigeria's leading human rights activists, has decided to take a public stand against the discrimination suffered by more than one million of his countrymen and women who are living with AIDS.

Soyinka, a former professor of medicine at Ife University in southwestern Nigeria, told *IRIN* that people living with the HIV virus and AIDS were often shunned by other members of society and treated like criminals.

But he warned that their marginalisation was a major factor causing the continued spread of the epidemic in Africa's most populous country.

Speaking on the sidelines of Nigeria's fourth national conference on AIDS in the capital Abuja, Soyinka said: 'The effort of promoting the rights of people living with HIV and AIDS has been ineffective in Nigeria. The criminalisation of HIV is always an issue.'

'We are worrying because the lack of respect for human rights increases the impact of the HIV epidemic,' said Soyinka, who now runs a non-governmental organisation called *Healthcare and Support*.

The professor, who is due to chair an International Conference on AIDS and Sexually Transmitted Diseases in Africa in Abuja next year, illustrated the impact of discrimination against people living with AIDS with a some pathetic examples from his own experience.

'How can we imagine that a child who lives in an auto park can escape from HIV infection?' he asked.

'What happened to this woman, a nurse, sacked from her job and unable to get a redress because the judge refused to allow her to come inside the court because she was HIV-positive ?' (see Joy Ezeilo's article)

'What about this 14-year-old girl, born in the north and sold to an old man, who ends up in a brothel in Lagos, unprotected but HIV-positive, 100 kilometres from her home?'

Soyinka said the government had yet to formulate and implement clear guidelines for ensuring that people living with AIDS were fairly and humanely treated.

'Unfortunately, we still lack a protocol policy,' Soyinka said. 'For more than five years now we have been concerned that we need a policy that we can use to address the issue of stigmatisation and discrimination.'

A recently published sentinel survey, based on the voluntary testing of pregnant women at antenatal clinics throughout Nigeria, indicated that one in 20 of Nigeria's estimated population of 126 million was infected with the HIV virus that will one day develop into full-blown AIDS. It also predicted that HIV prevalence would increase sharply over the next five yars.

Nigeria already has the third largest number of people living with AIDS in the world after South Africa and India.

Soyinka criticised the inadequate availability and distribution of antiretroviral (ARV) drugs that can improve the health of people living with AIDS and extend their lives.

The Nigerian government launched a pilot programme in January 2002 to provide subsidised ARV therapy to 15,000 people throughout the country at a cost of around US$7 per month. However, the project has been plagued by poor organisation and interruptions in the supply line of ARV drugs.

Soyinka described this pilot programme, which has shelved plans to increase the number of beneficiaries to 30,000, as grossly inadequate.

'Antiretroviral treatement is essential to life for one million people in Nigeria,' he said. 'But these drugs are not properly distributed, increasing the disparity between the "haves" and the "have nots".'

'It's one thing to provide antiretroviral drugs, it's another thing to get access to them,' he said. 'It's an area where we want to see changes and improvement.'

Soyinka lamented that for the most part in Nigeria, ARV treatment was only available to those who could afford the drugs at commercial prices. 'Commercial interest has supremacy over public health interests. All the rights of women, of children, of the minorities are violated,' he said.

Soyinka also complained about traditional healers who claim to offer AIDS cures, saying these were unlicensed and had not been scientifically proven to be effective.

'We've a situation today where "specialists" are conducting trials without ethical norms with disastrous effects on our population,' he said.

Soyinka accused these 'specialists' of experimenting with traditional drugs and all kinds of 'vaccines' on low-income and largely uneducated people, who cannot afford to buy medicine at free market prices, but still hope for effective treatment.

'Trying products on people without ethical backing needs to be stopped in this country,' Soyinka said. 'But the bottom line is there's no official ethical back-up.'

'In the area of ethics, human rights and HIV/AIDS, we've done too little and too late,' Soyinka said bitterly. 'It is high time to redress the situation.' – *IRIN News*

Defining the right to health: International and states' duties in relation to the HIV/AIDS epidemic

Several articles in the ICESCR (International Covenant on Economic, Social and Cultural Rights) help define the right to health. Article 12 of the ICESCR guarantees 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health' and instructs that the provision of these rights must be progressively realised. Article 2 instructs 'each State Party . . . to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures'.

The duty to 'progressively realise' the rights guaranteed by the ICESCR is demanding. Progressive realisation entails sustained and continuously increasing allocation of resources towards the realisation of these rights. However, the breadth of health measures necessary to satisfy the progressive realisation standard remains ill-defined. The drafters of the ICESCR left progressive realisation intentionally vague in order to allow individual states to determine the parameters of socio-economic rights within the abilities of each nation. Recognising this ambiguity, the Limburg Principles and the Maastricht Guidelines provide persuasive authority in defining various aspects of social and economic rights – including the right to health – and help define progressive realisation.

The Limburg Principles were developed in 1986 by a group of experts in international law considering the nature and scope of the obligations of states parties to the ICESCR. Along with the Maastricht Guidelines, the Limburg Principles are one of the benchmark standards for interpreting the ICESCR and have been used to help interpret the right to health. They provide insight into the measures or government actions that would achieve progressive realisation of the rights enumerated in the ICESCR.

Specifically, paragraph 21 of the Limburg Principles states, 'The obligation to achieve progressively the full realisation of the rights requires States parties to move as expeditiously as possible towards the realisation of the rights.' States must begin immediately to take steps to fulfill their obligations under the covenant. Further, according to the Principles, the obligation of 'progressive realisation' exists independently of increases in resources. It requires the effective use of available resources. Thus, not only must a signatory state intend to provide health care to all its citizens, but it must also move immediately to do so even if there are limited resources in the national coffers.

The effectiveness of the Limburg Principles was hindered by states parties' use of lack of resources as an excuse for not complying with the ICESCR. The Maastricht Guidelines remedied this weakness by refining and supplementing the Limburg Principles. The Guidelines mandate that 'State[s] cannot use the "progressive realisation" provisions in Article 2 of the Covenant as a pretext for non-compliance'.

Taken together, the Limburg Principles and Maastricht Guidelines provide guidelines for states to use in complying with the progressive realisation standard. If a state party does not continually take new steps to improve the general health of its citizens or fails to effectively address major impediments to health, such as epidemics like HIV/AIDS, it is not in compliance with its obligation under the ICESCR.

– *Roger Phillips*

Roger Phillips is the articles editor for the *Human Rights Brief*, from which this extract is taken.

Burundi: HIV-positive people demand protective laws

An association for HIV-positive people in Burundi, the *Reseau Burundais des personnes vivant avec le VIH*, wants the government to enact a law protecting affected people against discrimination and stigmatisation.

'We demand that the government should promulgate the law protecting HIV-positive people as soon as possible, not only to protect HIV-infected people but to protect the entire community,' Felix Ntungumburanye, the head of the association, said during a workshop in the capital, Bujumbura.

He said cases of discrimination against people living with HIV were on the increase. He added that to discriminate against an HIV-positive person contributed to the spread of the virus.

'In some parts of the country, some religious sects ask for certificates stating the HIV status before blessing marriages,' he said. 'The impact of this procedure is that people feel discriminated against and refuse to take the HIV test. Then weddings are held with all the consequences.'

The minister in charge of the fight against HIV/AIDS, Luc Rukingama, who opened the one-day workshop, said a bill protecting HIV-positive people against discrimination was being drafted and would soon be presented to the government for promulgation.

A participant, Chantal Ntihabose, 40, narrated the discrimination she had experienced since learning she was HIV-positive. 'I was afraid to tell my mother about my HIV status. One day she suspected I was positive and questioned why I liked visiting associations that assist HIV-infected people,' she said.

She added: 'When my mother discovered that I was HIV-positive, she threw me out of the house. That was in 1997. I asked myself how I would survive with my four children as I was jobless.'

She said an association taking care of people living with HIV, *Nouvelle esperance* (New Hope), helped feed her and her children. 'When my mother chased me away, I weighed 35 kg, now I weigh 60 kg, thanks to *Nouvelle esperance,*' she added.

HIV-positive people attending the workshop sought to have greater access to anti-retroviral drugs (ARVs) that could prolong their lives. Government statistics indicate that only 1,200 out of 25,000 people affected by HIV/AIDS in the country have access to ARVs. – *IRIN News*

Confronting the invisible crisis

Michael Fleshman

Last November, UNICEF in a report predicted that the number of African children who have lost at least one parent to AIDS will likely rise to 20 million by 2010. This means at least one in seven children in many countries will be left with only one parent. In some others, one in five children could become AIDS orphans. Much can be done to help these children. But the resources from the rich donor nations are not forthcoming.

To the tragedy of the 17 million people who have lost their lives to AIDS in Africa, add the 12 million orphaned children left behind. Traumatised by the death of parents, stigmatised through association with the disease and often thrown into desperate poverty by the loss of bread-winners, this growing army of orphans — defined as children who have lost one or both parents — is straining the traditional extended family and overwhelming national health and education systems in the most severely affected countries. The problem is particularly severe in Zambia, where, according to the US Agency for International Development (USAID), the number of orphans topped 1.2 million in 2000 — one in every four Zambian children. Of these an estimated 930,000 have lost at least one parent to AIDS.

Housing, feeding, educating and nurturing these children is both a moral imperative and essential to Africa's development prospects, Stephen Lewis, UN special envoy for HIV/AIDS in Africa, told *Africa Recovery*. 'There has to be a Herculean effort made for these kids so we don't lose them.' Otherwise, he cautioned, 'you reap the whirlwind.... You have a society where kids haven't been to school and therefore can't fulfil even basic jobs ... a society where a large proportion can have anti-social instincts because their lives will have been so hard. You have a generation of children who will be more vulnerable to exploitation and to disease because they won't have the same sense of self-worth.'

The needs of AIDS orphans are as immediate as their next meal and as extended as access to education, guidance and care until the end of their adolescent years. Speaking to leaders of industrialised countries at the July 2001 Group of Eight meeting in Genoa, UN Secretary-General Kofi Annan appealed for the resources 'to care for all whose lives have been devastated by AIDS, particularly the orphans'. The number of AIDS orphans exceeded 13 million globally, he noted, 'and their numbers are growing'.

Family collapse

In Zambia and other countries hit hardest by the pandemic, however, the traditional mechanism for the care of vulnerable children, the extended family, has started to break down under the twin pressures of poverty and disease.

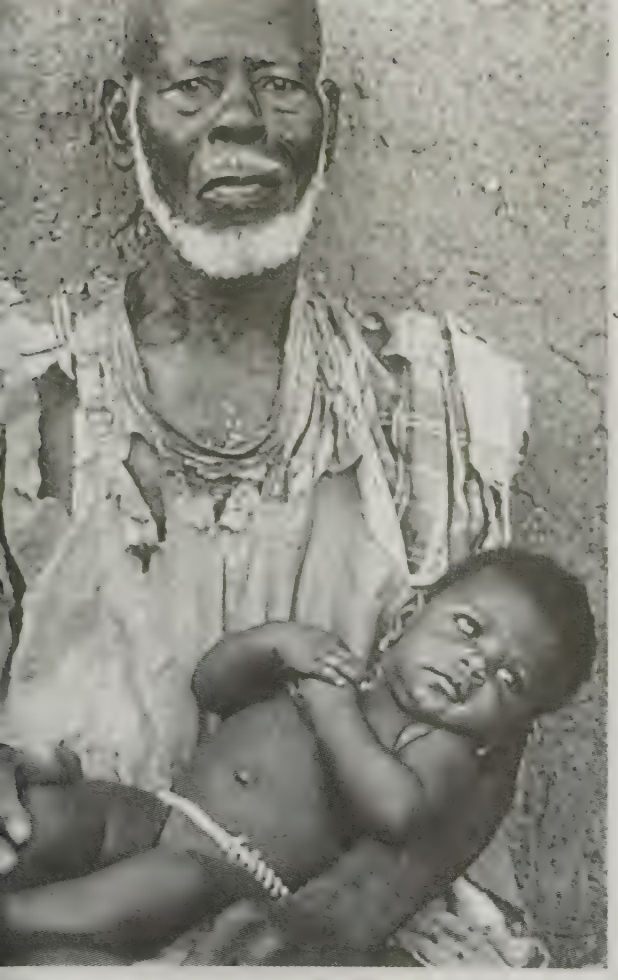
Reinforcing the family, UN Children's Fund (UNICEF) Executive Director Carol Bellamy says, is the only practical response to the crisis. 'There are not enough orphanages in this world to take care of these kids,' she noted. 'We've got to strengthen the extended family.' But a comprehensive 1999 study of what one researcher termed Zambia's 'silent crisis' of orphans revealed just how difficult that can be in practice.

Part of the problem is financial. The pandemic has been both a cause and an effect of the country's deepening poverty and rising external debt, problems that have pushed many families to the very edge of survival and limited the government's ability to respond to the orphan crisis. Per capita income, just $490 in 1990, slumped to $330 by the end of the decade, while debt service payments consumed a larger share of the national budget last year than did health and education spending combined.

For many children, the loss of parents brings destitution, an end to schooling and stigmatisation by family and neighbours. Despite the mounting death toll, nearly half of Zambia's orphans live in a household with one surviving parent, usually their mother. The high incidence of HIV infection within marriage, however, means that many children soon lose both parents, and become the responsibility of the extended family. About 40% of these children are raised by grandparents, while about 30% are reared by aunts and uncles.

The consequences for the family, however, can be devastating. One 70-year-old woman raising her four grandchildren told researchers that 'ever since these children were brought to me I have been suffering. I am too old to look after them properly. I cannot cultivate ... and the food does not last the whole year.'

'It is an unbelievable act of self-sacrifice on the part of the families because frequently it pushes them over the edge,' acknowledged Lewis. 'They have just enough for themselves and suddenly they take [in] two kids.... I don't think anybody imagined the unprecedented assault on the extended family



Africa Recovery

system which has occurred in grievously affected countries. This is just a huge challenge.'

Child-headed households, once a rarity in Zambia, are now increasingly common, but formal and traditional inheritance, land ownership, and health and education policies have not kept pace with their needs. 'Our parents both died in 1995,' one young Zambian woman told UNICEF researchers. 'When this happened, our relatives ran away from us. This surprised us because, being our relatives, we thought they would care for us.... Our parents had a big farm, but it was taken from us so we had nowhere to grow food. My young brothers and sisters became beggars; they would walk from house to house asking for food.'

Other children are taken in by neighbours, or find a bed in one of Zambia's very few orphanages or residential facilities. For the rest, there are only the streets of Zambia's cities, where children, lacking adult supervision and a stable home, survive by begging and petty crime.

Orphans or vulnerable children?

In Zambia, supporting the family's ability to raise orphans and other vulnerable children has been primarily a community effort. Over the nearly 20 years that the HIV/AIDS pandemic has spread through the country, hundreds of religious and community-based children's committees and homecare projects have been established to care for the sick and provide counselling and support for orphans and their families. The programmes are as diverse as the communities they serve. But in their various ways, virtually all attempt to help families meet two fundamental needs — food and education.

One of the first challenges communities face is determining what constitutes an orphan and which children should receive extra help. The 1999 study, supported by UNICEF and other donor groups, found that many Zambians consider children orphaned only if they do not live with an adult relative. In some communities children who have lost both parents but are under the care of some other relative may not be presumed to require special assistance unless they also are very poor. Many Zambians prefer the term 'vulnerable children' to 'orphan' because children with parents are often little better off in material terms than those whose parents have died, and are considered equally deserving of aid. The study found that while 75% of orphaned children lived below the poverty line, so did 73% of children with parents.

In one community, an external donor provided school fees and new uniforms for the children. The other students, however, could not afford new clothes. The resulting resentment isolated the orphans from their peers and raised tensions within the community. The same can occur within the extended family itself, where orphans under the care of an uncle may have access to benefits not available to the guardian's own children.

'When it comes to practical interventions,' the study noted, 'there is no useful purpose served by separating orphans from other vulnerable children. In fact, there are significant risks in so doing.' Part of the challenge facing donors, researchers note, is that many programmes earmark benefits exclusively for orphans — entrenching these 'significant risks' in the eligibility requirements.

Land and food

In rural areas, the government, religious and community organisations have worked with traditional leaders to keep vulnerable families on their land, and, where families are no longer able to provide for themselves, create sustainable nutrition programmes with local resources. In rural eastern Zambia, the Kanyanga Orphan Project (KOP) — originally established as an AIDS homecare programme — recognised an urgent need to improve the farming skills and nutrition of families with vulnerable children.

Traditional inheritance customs in the area usually allowed households headed by women and children to remain on their land, and the project initially supplied seeds, fertiliser and tools. When it became clear that families lacked the skills necessary to increase food production, the project hired a trained agronomist to improve agricultural techniques and yields. Originally conceived as a nutrition programme, KOP's farm project also became an important source of family income, allowing children to pay school fees, thereby reducing the financial burden on the community.

Nutrition projects in other parts of the country, however, have not fared as well. In Kitwe, the local Children in Distress committee (CINDI) established communally tended 'orphan gardens' to generate income for vulnerable families and improve nutrition. But the gardens routinely produced less than gardens worked for personal benefit and failed to reduce dependence on donated food rations and other external relief programmes. In the view of UNICEF and other researchers, the community's inability to hire professional staff, coupled with awareness that relief supplies would make up for low yields in the gardens, contributed to the problem.

The experiences of the Kanyanga and Kitwe nutrition projects reflect strengths and weaknesses in locally based responses to the needs of orphaned

and vulnerable children. In both cases, communities identified a need and moved quickly to improvise a solution, drawing on local skills and available resources. But the differences in the outcomes in the two communities point to the need for greater access to outside skills and financial and technical support, and highlight the difficulty of replicating local successes on a wider scale.

End to education

The Zambian government and civil society groups are finding similar challenges in trying to meet the educational needs of orphans and other vulnerable children. Although communities, parents and children themselves identify education as critical, the study noted in 1999, 'It is perhaps in the area of education that government, donors and the development community have failed the Zambian child the most.' Zambia's financial difficulties do not allow the government to provide free education. The government pays teachers' salaries, but local school management committees must cover operating costs by charging enrolment fees and setting requirements for uniforms. As a result, an end to education is often an early consequence of orphanhood and the loss of family income.

Children from poor families are most vulnerable. 'Our records show most of the orphan children stopping school are those coming from poor families,' noted a school headmaster in Katongo, Isoka.

In an effort to keep children in school, communities have developed three types of responses. The first is to lobby local school management committees to waive fees for the most vulnerable children. These efforts are often successful, but inevitably undermine the financial base of the school. At the Chimwemwe school in Kitwe, for example, fees were waived for 400 of the school's 1,500 students, reducing the operating budget by nearly a third.

A second community strategy is to raise money for orphans' school fees. Bursaries have the advantage of keeping schools solvent, but usually compel local committees to design and manage successful income-generating projects. With notable exceptions, however, communities often find they lack the management skills, start-up capital and marketing opportunities to run projects profitably. In many cases, community-initiated income projects lose money and drain volunteer committees of limited time and energy. Zambian government, donor and NGO advocates agree that improving communities' ability to generate operating revenue is vital, but it remains a long-term goal.

A third approach is the Open Community Schools programme — community-run schools without fees or dress codes created for vulnerable children using volunteer teachers, donated space and a curriculum that compresses the first six years into just three. Initially launched as an innovative government-community partnership to provide education to orphans and other vulnerable children, the schools were intended as adjuncts to the public school system rather than alternatives. Students were expected to return to the state system at year seven.

The success of the open schools triggered a rapid increase in their numbers, but often at the cost of educational quality. The reliance on volunteer staff meant that teachers were often absent, and left the school entirely when paid employment became available. As important as such stopgap measures are, educators argue, only a national system of free and compulsory public education can equip the next generation with the skills needed for development.

Institutionalising responses, not kids

The Kaoma Cheshire Home serves an area with the largest number of orphans in the country and is among the few programmes to provide institutional care for infants orphaned by AIDS. Yet it too aims to return the children to their communities as soon as circumstances permit, usually between the ages of two and three.

If there is consensus among advocates and service providers about the dangers of institutionalising orphans and other vulnerable children, there is equally broad recognition of the need to systematise and coordinate international, national and local responses. This role is increasingly being assumed by the Zambian government, with support from UNICEF and UNAIDS. At the national level, the Department of Public Welfare coordinates a steering committee of NGOs, civil society organisations and community-based providers to identify needs, direct technical and material resources where they are most needed and develop a policy framework that responds to the complex needs of orphans and vulnerable children.

There are also efforts under way to better use the resources of Zambian civil society groups, which have long grappled with the orphan crisis and accumulated valuable experience in mobilising people throughout the country to become involved. But unless a major increase in financial, technical and human resources occurs, said Lewis, the future of Africa's orphaned children is bleak.

'So many of the kids have gone through the desperate, traumatic ordeal of looking after a mother who literally dies in the child's arms,' he observed. 'They feel so abandoned. The little ones, the 4- and 5- and 6-year-olds, with these great big eyes, their little voices engaging you in this quiet whispered conversation — and you're trying to figure out what can be done for this seemingly endless roll-call of children. Communities try to make arrangements where kids can spend some time together, to have one meal if they can manage. But it's all very fragile.... Communities are so [besieged] by the dying and the death and the poverty,' he noted, 'that there just isn't enough time and concern focused on orphans, and there must be.' Sometimes, he concluded, 'it can be emotionally overwhelming.'

— *Africa Recovery* (October 2001)

Malawi struggles with the AIDS-orphan nightmare

World of Work

Gumisai Mutume

Volunteer community organisations do a heroic job, caring for orphans with minimal resources.

In a rural district along the shores of Lake Malawi, Catherine Phiri leads thousands of volunteers in a desperate rearguard battle against HIV/AIDS: feeding orphans, providing homecare, counselling and encouraging people to get tested. For six years, they have worked without financing from outside the area, relying on contributions from fellow villagers in this poor part of the continent.

'We can only bring the kids together once a week for a meal,' says Phiri, founder of the Salima AIDS Support Organisation (SASO). 'Apart from that, there is very little more we can do because we do not have the money. There is no funding at all for our orphan-care programme.' Set up in 1994 in response to the rising number of HIV infections in Malawi, where an estimated one in seven adults lives with the virus, SASO reaches 58,000 households in Salima.

It was only in 2000 that SASO, with its 2,650 volunteers, secured a grant of about $30,000 for its AIDS awareness programmes, but that runs out at the end of the year. 'Government helps,' Phiri told *Africa Recovery*. 'But it does not have a dedicated fund for orphan care.' After her husband died of an AIDS-related illness in 1990, she publicly declared her HIV-positive status and set up SASO.

There are hundreds of similar community organisations run by volunteers in Malawi, part of an extensive network coordinated through a national orphan-care task force established by the government in 1991. They have set up centres where children play, learn, are immunised and their health is monitored. Village committees assist children in desperate need, especially those looked after by elderly grandparents or parents who are very ill.

'The "grandmother phenomenon" is the dominant orphan programme for the moment, I think, in much of east and southern Africa,' says Stephen Lewis, UN special envoy for HIV/AIDS in Africa. 'It is a legitimate extended family arrangement and the kids by and large are related to one another and they are happy in that sense.'

'Where they have turned it over to the broader community, rather than a grandmother or part of the extended family, the arrangements are often make-shift and ad-hoc and the kids are struggling,' says Lewis. Of increasing concern to development planners is what happens when the grandparents die and, suddenly, child-headed households dominate.

Many orphans, little money

No one knows exactly how many AIDS orphans there are in Malawi. Estimates put the total number of orphans at 850,000 to 1.2 million, rising to two million by the end of 2002.

Resources are lacking to handle this growing orphan crisis. The government can only afford to allocate $250,000 for the gender ministry's social welfare department in 2001, notes Penston Kilembe, who is in charge of orphan care. 'It's inadequate. We need much, much more money than that because we are talking about survival, growth and the development of these children.' The government relies on the UN Children's Fund (UNICEF) for 80% of its child-care programme budget.

More than 365,000 Malawians have died of AIDS since 1985, when the virus was first diagnosed in this country of 10.6 million. Life expectancy has plunged from 52 years in 1990 to about 39 in 2000. The Joint UN Programme on AIDS (UNAIDS) puts the adult infection rate in Malawi at 16%.

Daunting challenges

The government acknowledges that its support 'has been grossly inadequate and the condition of orphans is made worse by extreme poverty and the erosion of extended families'. Malawi has, however, been praised for its humane and exemplary treatment of orphans despite the meagre resources.

UNICEF believes that political commitment is growing. President Bakili Muluzi is increasingly supportive of AIDS prevention and care programmes. In speeches, he frequently exhorts people to change their behaviour. He and his vice-president have both adopted AIDS orphans.

In 1992, Malawi became the first country in the region to develop guidelines for orphan care. These are being used as an example in neighbouring countries. They recommend that orphans be kept within their communities, and argue that government should be at the centre of national orphan-care activities.

But the government is losing many of its workers to AIDS. The health ministry estimates that by 2005 between 25 and 50% of workers in urban areas will die of AIDS. While the rates of infection are higher in urban areas, the number of people infected is greater in the rural areas, where 85% of the population lives. There, HIV/AIDS is presenting a daunting development challenge, diverting labour from farming into care provision, increasing food insecurity and threatening the survival of entire communities.

Breaking the poverty cycle

'Our biggest problem is poverty,' says Kilembe. 'At least 65% of our people live below the poverty line. Many are unable to take on the responsibilities of extra children because they are already strained.' Malawi's average annual per capita income is $200 – less than half the $500 average for sub-Saharan Africa.

Many of Malawi's poor children are not in school because they cannot afford to go. In 1994 the government abolished tuition fees for primary education, leading to an increase in enrolment from 1.9 million to 3.2 million the following year. But for many, the road ends there. Only a fifth of primary school graduates make it into high school. The danger of a generation of uneducated adults is all too obvious to development planners.

Elizabeth Hughes, of UNICEF Malawi, says the main approach to orphan care should shift from vocational training to formal education. 'When you go and speak to many of these children, they tell you what they really want is an opportunity to go to school,' says Hughes. 'We have to find a way of keeping them in school.'

— *Africa Recovery* (October 2001)

Namibia's orphan crisis set to worsen

Namibia's orphan crisis is set to worsen as HIV/AIDS continues to rob youngsters of their parents and a normal childhood.

When the Zambezi burst its banks and devastated huge areas of Namibia's Caprivi region over the past few weeks it was a repetition on a miniature scale of the vivid human drama of the Mozambican floods four years ago.

But the people in the region face a crisis far greater than the recurring curse of drought followed by floods and another drought. The true disaster remains largely unseen – it has a young face, sometimes even a smiling face.

Orphans don't photograph as well as floods and are not as dramatic as babies being born in trees. They don't look any different from other children, but they are - children orphaned or made vulnerable by HIV/AIDS often go hungry; are forced to become child labourers or sex workers just to get by; lack money for school and healthcare; face trauma and depression; and are at high risk of abuse, exploitation and HIV infection.

Nearly half the population of Caprivi – 43% – have HIV/AIDS and more than 20% of those aged under 19 have been left orphaned by the disease. There are already around 155,000 orphans in the country, while AIDS has caused Namibian life expectancy to plummet from its peak of 61.3 years in 1995 to just over 40 years today.

Countries with small populations, like Namibia, Lesotho and Swaziland, are particularly vulnerable to the impact of HIV/AIDS. A natural disaster like the recent floods is devastating to those already weakened by the disease, and without proper nutrition their bodies give in far more quickly. Sometimes there is a granny, an uncle, or a sister to look after the children they leave behind, but many are left unprotected and robbed of a normal childhood.

The orphan crisis is unlike anything that has happened before. It is estimated that in just 15 years' time, by 2021, some 10% of Namibia's entire population will be made up of children orphaned by AIDS.

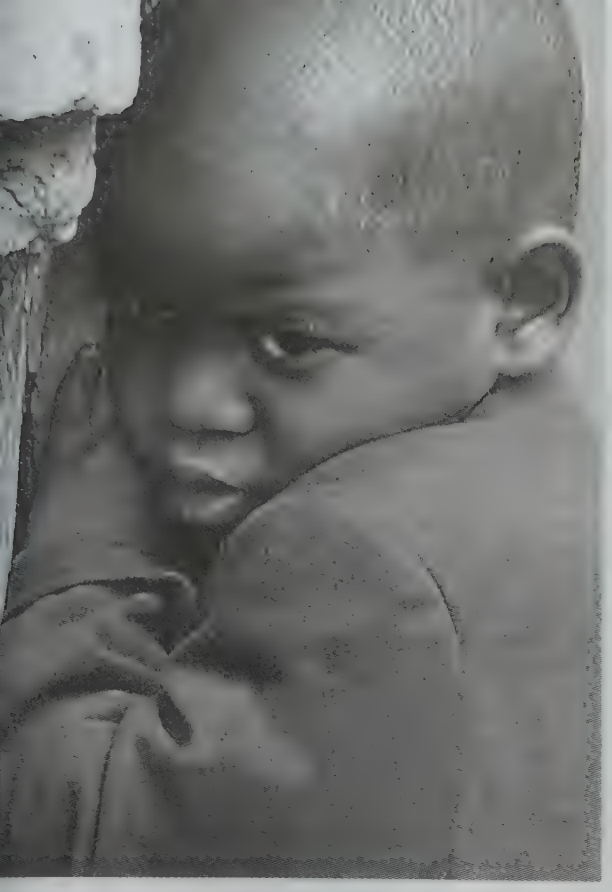
Their number is growing so rapidly that communities cannot cope. An Orphan Care Centre in Mafuta, a rural community at the eastern end of the Caprivi Strip, has been set up by the Namibian government and the UN Children's Fund (UNICEF).

The caregiver at Mafuta centre, Bridgete Sikute, has been trying to update the list of children in her care. 'Officially, there are around 180 orphans in our community,' Sikute says. 'But I think the number is higher than that. Certainly, it is increasing every day.'

It is simply beyond Bridgete and 12 other volunteers to even begin tackling the root causes of the orphan crisis in the region – extreme poverty, recurrent drought and floods, and the escalating HIV/AIDS epidemic.

For now, all they can do is provide care, support and, crucially, food for the orphans in their community. 'At home, these children have nothing to eat. That is why we decided to start this centre,' says Sikute. 'In previous years, orphans stayed in the bush rather than go to school because they were hungry. At least some of them now go to school.'

Free primary education and school feeding schemes have been vital to their survival. Sikute is keenly awaiting assistance from a joint emergency relief programme by the Namibian government, UNICEF and the World Food



Frontline

Programme (WFP), due to arrive in May.

The authorities have usually been able to provide enough aid to communities in need, but the scale of the current crisis in northern Namibia has forced the government to request international assistance.

"This is a very bad year – so many children need our help, but we can only feed around half our orphans at the moment. With WFP food aid, we might have enough to give them all at least two meals per day,' Sikute explained.

Carol Bellamy, Executive Director of UNICEF, has compared the HIV/AIDS crisis to having all the 'hallmarks of a full-scale war. But ... worse, because a war can be ended with far more ease than a pandemic.'

'There is no better gauge of its scale and cruelty than the orphan crisis – and the shameful inadequacy of the world's response to date,' she said recently.

For the people of northern Namibia that analogy is very real. They compare it to the war fought between the South African and Namibian fighters in Angola. 'We prayed in that time very, very hard so that the worst could be over,' said Marianne Shalumbu, who as chief community liaison officer of the Omusati Region is responsible for managing the orphan crisis. 'We do the same now.'

With the HIV infection rate growing, the worst of the orphan crisis in the region is yet to come.
– IRIN News

AIDS and Africa's legion of orphans

More than 11 million African children have lost at least one parent to AIDS, and that number is likely to rise to 20 million by the end of the decade, a report by the *United Nations Children's Fund* predicts.

Should that forecast hold, the report warned, at least one in seven children in a dozen sub-Saharan countries will have been left with only one parent because of AIDS. In some of those countries, more than one in five children are likely to become AIDS orphans.

It is largely unavoidable as well, the report said, because many African governments and wealthy donor nations have lagged in improving care and providing antiretroviral drugs for people with HIV, the virus that causes AIDS. As a result, many parents whose lives might otherwise have been prolonged are destined to die prematurely. 'The worst is yet to come,' the report said.

The organisation urged governments and relief organisations to try to head off the most damaging impact of a mushrooming orphan population by making childhood education free, providing aid to keep single- and no-parent families intact and finding 'safe and viable options' for orphaned children to earn a living.

In the vast majority of cases, orphans in the sub-Sahara are taken in by their relatives; less than 1% are left alone to head their households, the report said. But the spread of AIDS and the sheer number of children in need is overwhelming relatives who are themselves facing early death.

In Uganda, for example, one-third of the relatives who care for orphans and who have undergone HIV testing are themselves infected with the virus, studies show.

Uganda is one of the few fortunate countries where the level of HIV infection and AIDS cases appears to have stabilised or even fallen. 'We need to move beyond feeling beleaguered to feeling outraged by the unacceptable suffering of children,' Carol Bellamy, the organisation's director, said in a statement. 'The future of Africa depends upon it.'

Parentless children have long been a major problem in parts of sub-Saharan Africa, where youngsters in teeming shanty towns are prime candidates to become thieves or prostitutes. Moreover, AIDS is but a fraction of the orphan crisis: While 11 million children in the region have lost one or more parents to AIDS, the total number of single- or no-parent children in sub-Saharan Africa is a staggering 34 million.

The coming increase in AIDS orphans will raise the total of parentless children to about 40 million by 2010, the report forecast.

By 2010, according to UN forecast, more than one in five children in four countries – Botswana, Lesotho, Swaziland and Zimbabwe – will be missing at least one parent. At least one in seven children will be left without one or more parents in Burundi, the Central African Republic, South Africa, Rwanda, Malawi, Namibia, Zambia and Mozambique. — *International Herald Tribune*, 28 November 2003

Orphans 'most neglected' in war on HIV/AIDS

ORPHANS are the 'most neglected' part of the war against HIV/AIDS, 'perhaps because they are the living, and, for some, shameful reminders of a disease gone rampant', UNICEF Canada President David Agnew writes in a *Vancouver Sun* opinion piece. There are 11.5 million AIDS orphans in Africa, and the number could grow to 20 million by 2010, Agnew says. In Zimbabwe, although the majority of orphans are cared for by their relatives, the 'sheer number combined with the wretched economy ... has put enormous strain on those supports ... [and] orphans are increasingly left to fend for themselves', Agnew says. UNICEF's fight against HIV/AIDS has 'three major fronts': prevention, treatment and care for young people who are infected with and affected by the disease, Agnew says, adding, 'For their part, the orphans are struggling to make the best of their often-wretched lives.' Agnew says that the orphans continue to 'have their dreams', which are '[n]othing extravagant, and nothing beyond the reach of a caring world', concluding, 'But that's a world too few have experienced.'
– PAMBAZUKA NEWS No. 143 (www.pambazuka.org)

How AIDS will disrupt African society

A 15-year-old boy in Botswana has an 80% chance of dying of AIDS. Among the many ways that this is destabilising the continent, perhaps the most worrying is the exploding population of orphans.

Africa Recovery

The HIV/AIDS pandemic is producing orphans on a scale unrivalled in world history.

Those who die of AIDS often leave children behind, most of whom are not infected. Counting all those under 15 years old who have lost at least one parent, Africa already had 34 million orphans last year. By the end of the decade, that is predicted to rise to 42 million, half orphaned by AIDS.

A huge number of children without parental guidance is likely to spell trouble. Orphans are far more likely than other children to miss school, turn to begging or prostitution, fall sick, fail to be inoculated, pass on diseases, and die young. In Mozambique, 68% of children with both parents alive attend school, compared with only 24% of those with no parents.

Africa's orphans are far more numerous. Crowds of them congregate at traffic lights in Nairobi, Lusaka and Johannesburg, begging, sniffing glue and pilfering. Many are traumatised, having watched their parents slowly waste away and die. Most are shunned because of the stigma surrounding death by AIDS and the assumption that they carry the virus too.

Such children slip easily into delinquency. In ten years' time, the UN estimates that one-third of South African 18-year-olds will have no mother. Doug Webb of Save the Children, a global charity, predicts 'mass psychological problems'. Others link South Africa's high incidence of rape, especially of children, to the large numbers of men brought up in broken families in the 1970s and 1980s. If this is true, things can only get worse.

In the rest of Africa , the big worry is orphans with guns. They are 'putty in the hands of warlords', says Hamish Young of UNICEF. Abandoned children know their lives are likely to be short, so they figure they may as well seek thrills while they can. Gangs or rebel armies can provide substitute families, while orphans can make attractively nihilistic recruits. Children as young as five fought in civil wars in Sierra Leone, Liberia, Congo and Uganda, and have been responsible for many of the worst atrocities. Some observers think AIDS is partly to blame for the mayhem in Zimbabwe: the country has a million orphans and many more young men who expect to die young, easy recruits for land-grabbing militias.

Typically, a grandmother takes on children after her daughter dies. Where governments can afford to help, as in South Africa, Namibia and Botswana, bigger pensions and foster grants can keep families together.

But as today's grandparents die of old age, and the middle generation succumbs to AIDS, there will be fewer people to care for future orphans. Carol Bellamy, the head of UNICEF, says that AIDS and hunger have already placed an unbearable strain on over-extended families in southern Africa. She predicts 'an entirely disaffected, angry generation of children'.

Many children are left looking after their even younger siblings. Child-headed households are becoming common. They need help. But few African governments are prepared to give grants to minors; many do not even allow them to inherit property. Nor are they keen on building day-care centres or orphanages, even cheap village ones.

Much more could be done to keep infected parents alive. If cheap anti-retroviral drugs were widely and safely distributed and better food and nursing care made available, mothers and fathers could expect to live for several more years. Children would of course rather stay at home than go to granny or join a gang. But without massive foreign aid, Africa cannot afford much in the way of drugs, food or nursing. — *The Economist* (UK), 30 November 2002

Uganda beats back AIDS

Fred Kirungi

Uganda has shown that the tide can be turned against AIDS. Infection rates have been reduced through mass mobilisation, public education and strong support from the political leadership.

Uganda has recorded declining rates of HIV infection since 1993. Although HIV prevalence among pregnant women rose from 24% in 1989 to 30% in 1992, by 1999 it had dropped to 10%, according to the latest figures from the AIDS Control Programme (ACP) in the Ministry of Health. Among patients suffering from sexually transmitted diseases at Uganda's leading hospital, Mulago, HIV infection rates fell from 44.2% in 1989 to 23% in 1999.

This achievement can be attributed to four factors, according to Dr. Joshua Musinguzi, the acting programme manager of ACP: the high level of political commitment to the fight against HIV/AIDS, openness about the epidemic, involvement of all sections of society and the government policy of decentralisation. Even President Yoweri Museveni 'got engaged in the fight early and encouraged other political leaders to do so', Dr Musinguzi said.

A strong start

In 1986, the same year Museveni came to power, the government launched the ACP to spearhead the struggle against HIV/AIDS. The programme's objectives, according to Musinguzi, were to prevent further transmission of HIV, create mechanisms to care for the infected and their families and create the capacity to contain the epidemic. 'The backbone of our programme was information, education and communication. We had to make people aware of the problem and translate this awareness into behavioural change,' said Musinguzi.

The core of ACP's anti-AIDS message was abstinence from sex, faithfulness to one's partner and use of condoms. 'More people are now using condoms and there has been a decline in casual sex,' said Musinguzi.

The ACP alone distributed 80 million condoms last year, and the number is expected to rise to 120 million this year, compared to only 4 million in 1990. A June 2000 report shows an increase in condom use across the country. In Kampala, 51% of those surveyed used condoms in 1998 compared to 42% in 1995. The report also records a slight decline in non-regular sex partners from 14.1% in 1995 to 13.7% in 1998. However, condom use with non-regular partners increased significantly, from 58% to 76%.

Local councils

Musinguzi said the ACP conducted information campaigns on radio, television and in newspapers, distributed leaflets and posters and put up billboards across the country. However, because of the limited reach of these, especially in the rural areas, the programme also used existing administrative and social institutions.

'We especially used the LC [Local Council] system not only to get our message to every village but also ensure that anti-AIDS activities were initiated and implemented at the lowest level,' he said.

The LC system is a hierarchical administrative structure from the village to the district level. At each level, there is a governing committee composed of nine elected members, including secretaries for health, women and youth. The ACP trained LC officials at the district and in some cases, sub-county levels, and they, in turn, trained their counterparts at the lower levels on AIDS-related issues. 'Our approach was to encourage them to design and implement their own strategies to cope with the problem,' said Musinguzi.

Although there was no direct funding from the government for AIDS-related activities in the villages, LC committees were given assistance in the form of information leaflets, condoms and, in some cases, HIV testing services. Since 1996 when the government adopted the policy of decentralisation, 65% of tax revenues remains at the sub-county level and some of it is committed to AIDS activities.

In addition, the ACP used drama groups, schools, churches, mosques and community-based organisations to help spread the word on AIDS. 'Because of our openness about it, the challenge of AIDS became the concern of everybody. Churches, mosques, schools, the army, and even private companies initiated their own programmes to handle the problem', he said.

Combating stigma

Musinguzi said that openness about AIDS also helped remove the stigma associated with the scourge and encouraged people infected with HIV to join in the fight. One such group is the Buwolomera Development Association (BUDEA), set up in October 2000 in Iganga district, some 120 km east of the capital, Kampala. All 55 members of the group are infected with HIV, and 43 of them are women.

Florence Kumunhyu said they

formed the association not only to support each other, but also to help others in the community avoid their fate. 'We visit and give each other material and emotional support. Since we are all infected, we appreciate each other's problems and the dangers of this scourge more than anybody else,' says Kumunhyu.

Members of BUDEA visit schools, churches and mosques to preach against the epidemic. They also carry out door-to-door campaigns. 'People take an infected person more seriously. Our status is an advantage rather than a weakness in the struggle against the spread of HIV,' Kumunhyu says.

BUDEA receives no external funding, relying solely on the efforts of its members to finance its education and home-care activities. 'We rear chickens, grow crops and make handicrafts to raise money,' explains Kumunhyu.

Society-wide coordination

The members of BUDEA initially belonged to a larger non-governmental organisation, Integrated Development Activities and AIDS Concern (IDAAC). Formed 10 years ago, the NGO operates in the three districts of eastern Uganda.

'We went to the villages encouraging people to come for HIV testing. We provided our members with home care support and counselling,' said Rev. Jackson Muteeba, IDAAC's programme manager. As the numbers grew, however, IDAAC found it difficult to provide these services. 'We encouraged them to form local associations so that they could support each other. Intervention measures are more effective and sustainable if they are applied from the lowest level, right from the home,' Muteeba said. The group, with over 4,500 registered HIV patients, provides its member associations with training and advisory services. There now are over 1,500 NGOs and community-based organisations involved in HIV activities in the country.

Musingusi noted that it was the involvement of different sectors of society that originally led to the formation of the Uganda AIDS Commission (UAC) in 1992 to coordinate all AIDS activities. The UAC's director of AIDS research and policy development, John Rwomushana, explained that under the multi-sectoral approach the commission adopted in 1993, the struggle against AIDS was broadened to include fighting poverty, illiteracy, child abuse and cultural practices like polygamy and wife inheritance, all of which make individuals more vulnerable to HIV infection.

Mobile team with a young AIDS sufferer in Kampala.

Overall, AIDS-related activities are expected to cost $181 million over the next five years, according to the UAC. The government will contribute $60-88 million, with the shortfall expected to be taken up by NGOs and donor agencies.

Cultural sensitivities

'Our education campaigns not only addressed AIDS and health-related issues', said Rwomushana, 'but also risky cultural practices. HIV control was made an integral part of the country's national education and poverty eradication policies'.

One of the biggest challenges, according to Rwomushana, was how to campaign against AIDS and risky behaviour without upsetting cultural and religious sensibilities. 'We adopted a policy of inclusiveness that avoids confrontation with the different social and religious groups,' he said. 'The fact that the chairman of the Uganda AIDS Commission, Halem Imana, is a retired Catholic bishop is a demonstration of this.'

One policy that posed particular problems was the promotion and distribution of condoms. Many religious groups were opposed to them, prompting the ACP and UAC to not be very forceful in promoting them in the beginning. That obstacle has now been overcome, according to Rwomushana.

'We encourage groups that preach morality to promote means of HIV avoidance they are comfortable with, without, however, undermining other agencies that may be promoting methods less acceptable to them,' he said.

Big challenges

Despite all these achievements, there are serious challenges to be faced, not least the growing number of AIDS orphans. According to UAC, there are 1.9 million Ugandan children who have lost one or both parents to AIDS. 'The challenge is to provide them with housing, food and education,' says Rwomushana, who is in charge of formulating a national strategy to address the problem of orphans.

Another big challenge, according to Musinguzi, is reducing the comparatively high prevalence of

Profile: AIDS in Uganda

People living with HIV/AIDS (1999)	823,000
of which:	
women (15-49 years old)	420,000
men (15-49)	350,000
children	53,000
Adult HIV prevalence rate (%)	8.3
Estimated AIDS deaths to 1999	110,000
Children who have lost one or both parents	1,700,000

Source: UNAIDS, UN Economic Commission for Africa, *AIDS in Africa: Country by Country, 2000.*

HIV among girls aged 15-19 years. A March 2001 UAC report noted that girls are six times more likely to be infected with HIV than boys the same age. Musinguzi attributes this to the 'sugar daddy' syndrome, referring to older, relatively wealthy men who engage adolescents in sexual relationships. 'A broad approach that involves enrolling and keeping girls in school and equipping them with skills to resist such men is needed,' he says.

Anne Akia Sydler, editor of *Straight Talk*, a free monthly magazine that targets adolescents, agrees. 'Girls fall easy prey to sugar daddies because they have no bargaining power. *Straight Talk* is trying to equip these girls with bargaining and communication skills,' she says.

Daunting as these challenges are, Rwomushana has no doubt that they will be surmounted. 'With the involvement of everybody, we have managed to bring the infection rates down. There will be no complacency, and the situation can only improve,' he says.

– *Africa Recovery* (June 2001)

HIV rates drop 70% with prevention campaign

HIV prevalence in Uganda has dropped 70% since the early 1990s primarily because of a 'successful' public HIV/AIDS prevention campaign that encourages avoiding 'casual' sexual activity, according to a study published in the April 30 issue of the journal *Science*, *BBC News* reports.

Drs. Rand Stoneburner and Daniel Low-Beer of University of Cambridge in the United Kingdom analysed population-level HIV and behavioral data from Uganda and neighboring countries – including Kenya, Malawi and Zambia – to assess the validity and determinants of declines in HIV prevalence and examine the potential influences of prevention interventions.

The researchers found that 'important' behavioral changes occurred among the Ugandan population between 1989 and 1995, including an increase in the age of first sexual intercourse, a decrease in indicators of casual or nonregular sexual partners and an increase in condom use with both casual and regular sexual partners, according to the study.

In addition, an 'important and perhaps overlooked' measure of behavior change during this time was a 60% reduction in the number of people in both rural and urban areas who reported casual sexual relationships over the previous year, according to the study. The study suggests that a reduction in the number of sexual partners in the general population and a delay in onset of sexual activity among unmarried youth, especially in urban areas and among males, are the 'relevant factors in reducing HIV incidence'.

Although condom use in neighbouring countries was just as common as in Uganda, condom use may not be sufficient to cut HIV incidence without a reduction in casual sex as well, according to the study, *Reuters Health* reports.

Stoneburner and Low-Beer also suggest that communication about HIV/AIDS through social networks and personal contact with HIV-positive people or people who have died of AIDS-related causes also helped to lower HIV prevalence in Uganda.

Shift in 'strategic thinking'

The Ugandan government's national HIV/AIDS prevention campaign 'clearly communicated the reality of the AIDS epidemic in terms of a rational fear of the risks of casual sex, which drew on and mobilised indigenous responses at the community level', according to the researchers.

The government's messages that AIDS, which is also known as 'slim' in Uganda, is fatal and that individuals should practice 'zero grazing', or monogamy, were clearly communicated, and condoms were a 'minor' component of the original strategy, according to Stoneburner and Low-Beer.

The researchers say that the 'substantial' reductions in Uganda's HIV prevalence – which are equivalent to results that might be seen with a 'highly effective', although as of yet undeveloped, vaccine – 'resulted from public health interventions that triggered a social process of risk avoidance manifested by radical changes in sexual behaviors'.

According to the researchers, the behavioral changes resulting from Uganda's prevention messages may not transfer with the same success or be appropriate for other countries.

However, in order to successfully replicate the lessons learned from the Uganda model, Stoneburner and Low-Beer conclude that 'a shift in strategic thinking on health policy and HIV/AIDS, with greater attention to epidemiological intelligence and communications to mobilise risk avoidance', is needed.

— *kaisernetwork.org*

Senegal's recipe for success

Early mobilisation and political commitment keep HIV infections low

Mamadou Mika Lom

Senegal is one of the countries cited as an example in the struggle against AIDS in Africa. Since its first confirmed case in 1986, the prevalence rate of HIV infections among adults has been kept at between 1.77 and 1.74%. Around 80,000 adults and children are infected, out of a total population of nine million.

The reasons for this success against the spread of the virus lie in Senegal's early response to the disease, vigorous preventive action, care of AIDS patients and the mobilisation of people at all levels, including teachers, soldiers, women, religious leaders and non-governmental organisations (NGOs). Senegal's long experience with democracy and its freedom of the press also made it possible to openly discuss the problem and easily get out information about the disease.

In 1970, well before the discovery of the first AIDS case, the government already had initiated a policy for managing blood transfusions. It was strengthened after 1986 through the systematic screening of donated blood. And to better keep the disease from spreading among prostitutes, the health authorities very early established a system for addressing their health needs, as well as a programme against sexually transmitted diseases.

Bonds of trust were forged early on between medical experts and government officials, who were convinced of the stakes involved, and allocated budgetary resources to fight the disease. They launched a national committee to combat AIDS in October 1986.

Aware that all these initiatives would have only a limited impact if they were not accompanied by other measures, health officials in 1988 launched a national campaign aimed at women and young people, particularly students. Teaching modules on the links between AIDS and other sexually transmitted diseases were made part of school curricula. These target groups in turn helped to raise the awareness of other especially vulnerable and high-risk groups of the population, such as prostitutes and migrant workers.

Senegal was also among the first countries in Africa to take advantage of the new opportunities to gain access to anti-retroviral medicines, to care for those who have become infected. The average cost of basic medicines for treating AIDS-related diseases has been reduced by 90%. In addition, President Abdoulaye Wade has committed the government to doubling the amount needed for anti-retrovirals, from CFA 250 million to CFA 500 million (about $700,000) per year.

Peer education

In support of these programmes, the interventions were decentralised at all levels by establishing numerous awareness-raising projects among community organisations, especially cultural and sports associations and women's groups. Centres for young people were set up in different regions, to promote the use of condoms and 'peer education', in which young people knowledgeable about AIDS talk primarily to other young people.

'This method has the advantage of getting around the obstacle of sexual taboos' and the reluctance of youth to talk about sex in front of adults, says Ami Seck, a high school student belonging to the sports and cultural association in Louga. 'Among themselves, young people are able to say everything, looking each other in the eyes, without any qualms.'

The overall formula in the schools, notes Seck, is that 'the teachers speak to the students, and then they in turn talk to people their own age and to members of their neighbourhood associations'. A similar system is used with women's associations.

Health minister & AIDS specialist

Dr. Awa Marie Coll Seck, a specialist in HIV/AIDS and other infectious diseases, was named Senegal's new minister of health and prevention on 12 May 2001. She has long been active in AIDS education and prevention activities, working with Senegal's national committee against AIDS since its formation in 1986. Three years later she launched a non-governmental organisation dedicated to highlighting women's particular vulnerability to AIDS, and directed the group until 1996. She subsequently joined the staff of the Joint UN Programme on AIDS (UNAIDS) in Geneva, before taking on her new duties as minister.

Dr. Seck's appointment is noteworthy in several respects. Until recently, it has been rare for health professionals to actually attain ministerial office, a rank usually reserved for influential political figures. Like a number of other 'civil society' ministers in the new government, which was formed in the wake of the 29 April 2001 legislative elections, she does not belong to any party. She also is one of a record number of six women in the cabinet, including Prime Minister Mame Madior Boye.

Africa Recovery

Women's cooperation in Senegal: community groups have been key in spreading information about AIDS.

Religious leaders in the forefront

About 95% of Senegal's population is Muslim and 4 % Christian. Religious authorities, both Muslim and Christian, have been very actively engaged in the battle against AIDS. They have organised workshops and conferences, of which the most important was an international colloquium on 'Religion and AIDS' held in Dakar in 1997, with the participation of representatives of Islamic, Christian, Buddhist and other religious communities from around the world.

From the outset, the Muslim leaders have refused to talk about condoms, preferring instead to emphasise in their sermons fidelity and abstinence as the best means for preventing the disease. They do not, however, exclude the possibility of a couple using condoms if one of them is infected. They also have done successful work in countering discrimination against infected people, some of whom previously had been rejected by their close families and communities.

Changing the behaviour of people is most important, stresses Bamar Guèye, coordinator of the Islamic NGO *Jamra* (Arabic for 'embers'). 'We have always insisted on the moral quality of the individual in our messages,' he says. It was Jamra that succeeded in mobilising the *khalifs* (spiritual leaders) of the main Islamic brotherhoods of Senegal to openly discuss the problem of AIDS.

Sida Service, a Christian NGO, also is heavily involved in the fight against AIDS. It is the only NGO to operate a centre that conducts free and anonymous screening for AIDS. Executive Secretary Paul Sagna acknowledges that his group does not reject the use of condoms, but most often advises 'abstinence and fidelity'.

Risky cultural practices

According to Bineta Bocoum, an official of the health education office in the Louga region (which has a high concentration of people who are HIV-positive), it is very difficult at the moment 'to say who, among men and women, are the most infected with the disease in Senegal'. Bocoum, who also is an active member of the Society for Women Against AIDS in Africa, adds that it is particularly risky to specify infection rates among prostitutes. While 'official' prostitutes are well monitored and well educated about the disease, others practice the trade more clandestinely. Nevertheless, she is encouraged by the fact that information about the disease has been widely disseminated by NGOs and women's, youth and religious associations.

One problem, however, is that many of the cultural practices that are prevalent in Senegal may serve to propagate the spread of the disease. These include the *levirate*, in which a man is obligated to take as his wife the widow of a deceased brother, or the *sororat*, in which a woman marries the spouse of her late sister. Polygamy and excision (female genital mutilation) also are widely practised. Fortunately, the involvement of religious leaders in raising awareness about AIDS has contributed to reducing such practices. As some of these authorities now emphasise, no one should be obliged to marry if it 'runs the risk of losing your life'.

Soldiers targeted

Army soldiers are regarded as the biggest consumers of condoms in Senegal. This is because special steps have been taken to raise the awareness of troops, in order to prevent the spread of AIDS. The success at this level lies with the fact that Dr. Souleymane Mboup, a colonel in the army's medical corps, has himself been deeply involved in research on the disease. He was part of the effort to isolate HIV-2, a particular strain of the malady discovered in Senegal, and he has received numerous distinctions for his research.

Generals in the Senegalese army often receive training about AIDS from military doctors, and in turn are expected to raise the awareness of their troops and the troops' families. During every peacekeeping mission involving Senegalese contingents, explained a military doctor, 'the troops are well-educated about the disease and given sufficient numbers of condoms'. While on mission, these troops also regularly undergo examinations and screening, the same source indicated.

Among private businesses, the emphasis is on preventive action. This is especially the case in the country's big enterprises, such as the *Industries chimiques du Sénégal*, a phosphate mining and processing complex in Thiès, and the *Compagnie sucrière sénégalaise*, a sugar plantation and milling enterprise in Saint-Louis. According to Papa Nalla Fall, a leading employers' representative, 'everything is being done to safeguard workers from the disease'.

'Since businesses are not isolated from society,' says Fall, 'it is therefore necessary to be concerned with the employee's immediate environment, and beyond that, with the entire community to which he belongs, to avoid eventual losses of time and money for the enterprise.'

Fall took part in the December 2000 African Development Forum organised by the UN Economic Commission for Africa, which focused on the AIDS crisis. At the

forum, he urged the reduction of developing countries' debts, so that they can devote more resources to the fight against AIDS. Upon his return to Senegal, he and other private employers initiated a series of seminars to stress the importance of disseminating information on AIDS within businesses.

A stable infection rate

In the 17 years since Senegal's first AIDS case was diagnosed, the HIV infection rate has been kept stable. Of the 80,000 or so Senegalese living with the virus, about 3,000 are children. Initially, there were about four infected men to every infected woman, but now the ratio is about equal.

According to medical experts, prostitutes, or 'sex workers', are the group most exposed to the disease. Their prevalence rate is between 12 and 15%. Dr. Ibra Ndoye, director of the National Programme Against AIDS and head of a major AIDS treatment and research centre at Fann Hospital in Dakar, notes that this rate compares favourably with the average for prostitutes in Africa, about 50% of whom are believed to be infected. 'The rate of infection of prostitutes is not alarming in Senegal', he maintains, adding that since 1988 the rate of new infections among Senegalese prostitutes has not changed. He attributes this to effective work on monitoring the population in general, and sex workers in particular.

The overall infection rate may climb somewhat over the next few years, but according to Ndoye, the goal is to not exceed 3% between now and 2005.

'The greatest difficulty that we are now confronting', says Ndoye, 'is the problem of access to medicines, whose prices still are too high for those who are sick'. Another difficulty is the lack of information among doctors responsible for dealing with the disease. 'AIDS is a new illness that requires a new approach among specialists involved in treating it', he says. Therefore better training and more medical personnel are needed to mount an even more effective response against the spread of the virus. – *Africa Recovery* (June 2001)

Botswana's high-stakes assault on AIDS

Roman Rollnick

Through private-public partnership effort, Botswana tackles the AIDS epidemic with free drugs, and an aggressive education campaign.

The gleaming floors, white-frocked technicians and humming electronic equipment of the Botswana-Harvard HIV Reference Laboratory in Botswana's capital are distant in more ways than geography from the dusty villages and crowded mining compounds on the frontline of Botswana's desperate struggle against HIV/AIDS. But closing the gap between the resources available at this modern new facility, and the nearly 40% of the adult population infected with the deadly virus, is at the heart of Botswana's high-stakes effort to provide comprehensive HIV/AIDS treatment to all of its citizens. Botswana became the first country in Africa to offer expensive, but life-saving, anti-retroviral drugs (ARVs) and other medications to all who need them through the public health system.

It is a costly and ambitious undertaking, one that many

Botswana's AIDS epidemic, 2001

Population	1.6 million
Adult population (15-49)	762,000
Total adults with HIV	300,000
Adult infection rate	38.8 %
Adult women with HIV	170,000
Adult men with HIV	130,000
Children with HIV (0-14)	28,000
Older adults with HIV (50+)	2,000
Total deaths (2001)	26,000
AIDS orphans (0-14)	69,000
Life expectancy (1987)	63
Projected life expectancy (2005)	37

Source: UN Africa Recovery from UNAIDS, World Bank data

Profile: AIDS in Senegal

People living with HIV/AIDS (1999)	79,000
of which:	
women (15-49 years old)	40,000
men (15-49)	35,700
children	3,300
Adult HIV prevalence rate (%)	1.8
Estimated AIDS deaths to 1999	7,800
Children who have lost one or both parents	42,000

Source: UNAIDS, UN Economic Commission for Africa, *AIDS in Africa: Country by Country, 2000.*

Africa Recovery

Young Botswanan activists have been key in public AIDS education and prevention programmes.

healthcare experts say cannot be done in Africa. But for the 330,000 Botswanan adults estimated to be HIV-positive, access to ARVs and to ongoing care, counselling and testing, is a matter of life or death. The vast but sparsely-populated territory has the highest HIV infection rate in the world (see table, below). Some 26,000 people in this country of less than 1.6 million died from AIDS-related illnesses in 2001 alone. 'We are threatened with extinction', President Festus Mogae told the UN General Assembly. 'People are dying in chillingly high numbers. It is a crisis of the first magnitude.'

More than Botswanan lives may be at stake, however. For years, some international health experts, backed by many donor governments and agencies and the powerful pharmaceutical industry, have argued that poverty and the absence of infrastructure make it impossible to successfully treat large numbers of HIV-positive people in developing countries with AIDS medications. Rather than waste resources on a failed effort to treat those already ill, they assert, scarce funds should be spent preventing new infections through education and prevention programmes.

Activists counter that pilot projects have demonstrated the feasibility of treatment programmes in developing countries, and that only a combination of treatment and prevention can turn the tide against the disease. Many advocates charge that opposition to large-scale treatment programmes is fueled more by concerns for patent rights and profits than genuine doubts about practicability.

Botswana is the first African test case. Success in treating large numbers of patients will buttress the argument for greatly expanded treatment efforts in the rest of Africa and other developing regions. Failure will badly undermine the call for greater treatment access for the world's poor. Although the Joint UN Programme on HIV/AIDS (UNAIDS) has long maintained that both prevention and treatment are necessary in the campaign against AIDS, fewer than 30,000 of the almost 29 million Africans infected with the virus have access to the ARV drugs that have dramatically reduced death rates in rich countries.

Slow but steady progress

If any country in sub-Saharan Africa can implement a comprehensive HIV/AIDS prevention care and treatment programme, observers say, it is Botswana. Unlike many of its neighbours, the country has enjoyed an unbroken period of peace and comparative prosperity since independence in 1966. Its government is widely regarded as among the most efficient and capable on the continent, and its annual per capita income of $3,300 is among the highest.

Still, the obstacles are formidable. Many Botswanans are migrant workers, employed in neighbouring South Africa for much of the year, but maintaining farms and families back home. Migrants are at particular risk of infection because of the increased likelihood of contact with prostitutes and other casual sex partners while away from home. Often unaware that they have become HIV-positive, and unwilling to seek out testing and counselling because of the stigma associated with the disease, migrants are thought to be an important factor in the spread of the virus.

For those who do seek medical help, there is the problem of locating it. For HIV patients outside the private sector, there are only two government referral hospitals, one in Gaborone and another in the north, in Francistown. There are two smaller, district hospitals in the country, but most public health care is delivered through local clinics offering only basic services.

The National AIDS Coordinating Agency (NACA) formally embarked on the national treatment programme in January 2002. Dr. Banu Khan, NACA's national AIDS coordinator, reported that the government set a target of 19,000 people for enrolment in their first year of ARV treatment under a $27.5 million programme in which people who require the drugs will get them for life. The ministry of health has calculated the cost of medications, testing and counselling at about $600 per person, per year. Over the first five years of the programme, the Gates Foundation will provide $50 million to help Botswana strengthen its primary health care system, while the giant US drug manufacturer Merck will match that contribution with anti-retroviral medicines. The other half of the cost, some $100 million, will be met by the government.

'As of June this year, we had an estimated 1,000 people enrolled,'

Khan noted. 'We have 500 undergoing the treatment, while the remainder are still being screened to ascertain their precise treatment requirements.' She termed that number 'disappointingly' low, but said that more people are steadily coming forward. NACA says the volunteer patients include a 'good mix' of educated and poorer rural people, some from the remote regions of the arid Kalahari in the west and northwest of the country.

Significantly, NACA officials say, initial indications are that very few patients have difficulty adhering to the complex ARV drug treatment regimes. The ability of poor and poorly educated patients to stick to strict medication schedules over a lifetime has been a major concern of health specialists and is an important aspect of Botswana's treatment initiative. Like Alcoholics Anonymous, NACA operates a 'buddy system' whereby each patient is encouraged to form a special bond with someone close, who makes sure they remain on their medication schedule. The patients, in turn, counsel others who feel they may need help, to come forward.

Targeting mothers

Enrolling women in the programme is a key priority because they make up more than half of all infected adults. Dr. Khan said that NACA is especially concerned at the low intake of mothers in a programme intended to cut mother-to-child transmission of the HIV virus and keep infected mothers alive. Since the pilot project began, she said, only 2,000 women are currently undergoing treatment for AIDS-related illnesses. 'We only opened up pilot sites two years ago. The percentage of mothers enrolled, however, is not desirable. It is low and must be increased. We have problems here, especially the one of stigma.' Health officials said enrolment by pregnant mothers had only been in the 11-20% range.

'Another problem is the status of women in relation to men,' Khan added. Many women lack the power to control decisions about sexuality and remain under the authority of husbands, parents and in-laws all their lives. 'How do you test someone if they do not get permission?' Khan asked.

'Then, with those who do enrol, they go home to a remote village with formula milk for their baby and are branded as suspect because they are not breast-feeding.... Mothers also worry about who will look after their baby if they die. But ARV therapy is now available in Botswana for these mothers and their babies, and I am hoping [enrolment] will increase now.'

The country currently has 16 voluntary counselling and testing centres specifically for mothers, one in every district. These are stand-alone centres where one can discuss medical problems in privacy. 'For example, in the latter part of last year, we had a conference for people living with HIV/AIDS and it drew 500 sufferers,' Khan noted. 'They went back to their homes and formed support groups to reduce stigma.'

Khan said that NACA urgently needs more trained staff. 'We have found that if you have a trained nurse dealing with many people in a rural clinic, for example, she does not have the time to counsel every HIV patient. So we are building a system of lay counsellors, like social workers. For this, we do not necessarily need nurses and we have a programme to employ 500 such lay counsellors. We are hoping they will also play a key role in reducing stigma.'

She said that people living with AIDS, from both the educated urban classes and rural communities, are increasingly aware that the government is providing free lifelong treatment. 'These people are with us on a voluntary basis. No one is coerced. We counsel them on positive living, about prevention, about the importance of remaining on the treatment even if they feel better. And they usually go home and spread this positive message.'

Staff shortages severe

At present, NACA employs 10 doctors working full time on HIV/AIDS at the Princess Marina Hospital in Gaborone, and five at each of the other hospitals. Patients are also seen at the smaller health facilities, some of them mobile clinics, around the country. Uniquely for an African country, NACA says, almost no one is more than 8 km away from a clinic where they can seek medical help. Even in the remotest areas of the Kalahari, most people are just 15 km away. These clinics decide what sort of treatment people need, and either refer them to a hospital or provide them with ambulance transport if required.

Catherine Sozi, a British-trained Ugandan doctor based at the UNAIDS office in Pretoria, South Africa, said Botswana can sustain its national health scheme for AIDS patients even though the drugs are required for life. 'However, there is an acute, absolute shortage of doctors, nurses and counsellors in Botswana's healthcare system,' she said, citing a recent UNAIDS assessment. 'Although we did not have time to calculate the number of extra health workers needed for the ARV programme, the numbers are substantial. If a first recruitment for ARV treatment would cost one hour of a doctor's time, recruiting 10,000 new patients in three months, for example, would require at least 20 full-time doctors doing nothing else but supervising these patients.'

The shortage of doctors, pharmacists, nurses and counselors is compounded by the fact that over 90% of doctors in Botswana are foreigners who do not speak Setswana. Counsellors too are recruited from abroad and need to spend time becoming familiar with the local culture. Many spend only a brief period in the country, thus exacerbating the need for frequent training and supervision to ensure proper medical care. There also is concern that many nurses, once trained and registered, emigrate to better-paid jobs abroad.

The government is seeking to recruit up to 200 new doctors from South Africa, Cuba and other nations to administer the drug programme. 'In return for their travel and accommodation expenses, many are coming to give

their time free of charge,' Khan explained. 'They know the government is serious in addressing this epidemic.'

The shortage of pharmacists outside the major hospitals is another problem. UNAIDS found that Botswana's few pharmacy technicians already have to manage drug supplies and distribution in the hospital and surrounding clinics. 'They need support if they are to handle sensitive drugs like ARVs,' Sozi said. Because Botswana will have to rely for some years to come on foreign health professionals, she noted, UNAIDS is recommending appropriate courses for them about local culture, health policies and protocols. Many current staff will require crash courses on ARV treatment issues.

Testing, monitoring and surveillance of the Botswana AIDS plague, as many now call it, is carried out by the new Botswana-Harvard laboratory at the Princess Marina Hospital. The first of its kind anywhere in Africa, the laboratory, with a staff of 50, is equipped with gene sequencers and blood cell sorters, enabling scientists to keep track of the spread of HIV, especially the HIV-1C strain prevalent in Africa.

The lab will also conduct research for the development of new medicines, including a vaccine. 'The virus strain in Botswana is clearly different from those we see in the West,' said Max Essex, Chair of the Harvard AIDS Institute. 'Nobody knows if a vaccine [being developed] against HIV-1B, the strain most common in Europe and the US, will work as well against HIV-1C.' Scientists at the institute said they are concerned that strains like HIV-1C would become even more drug resistant without effective monitoring of patients taking ARVs. This is why, Khan said, the 'buddy' system to ensure adherence is as important a component in the battle as further funds for training new medical teams.

Treatment and prevention

Botswana is supporting the new drug treatment policy with an expanded and more aggressive education campaign, modelled in part after Uganda, which has successfully reduced new HIV infections through sustained public education. President Mogae is determined to make sure that the message of free treatment gets out — through radio, billboard campaigns and by word of mouth.

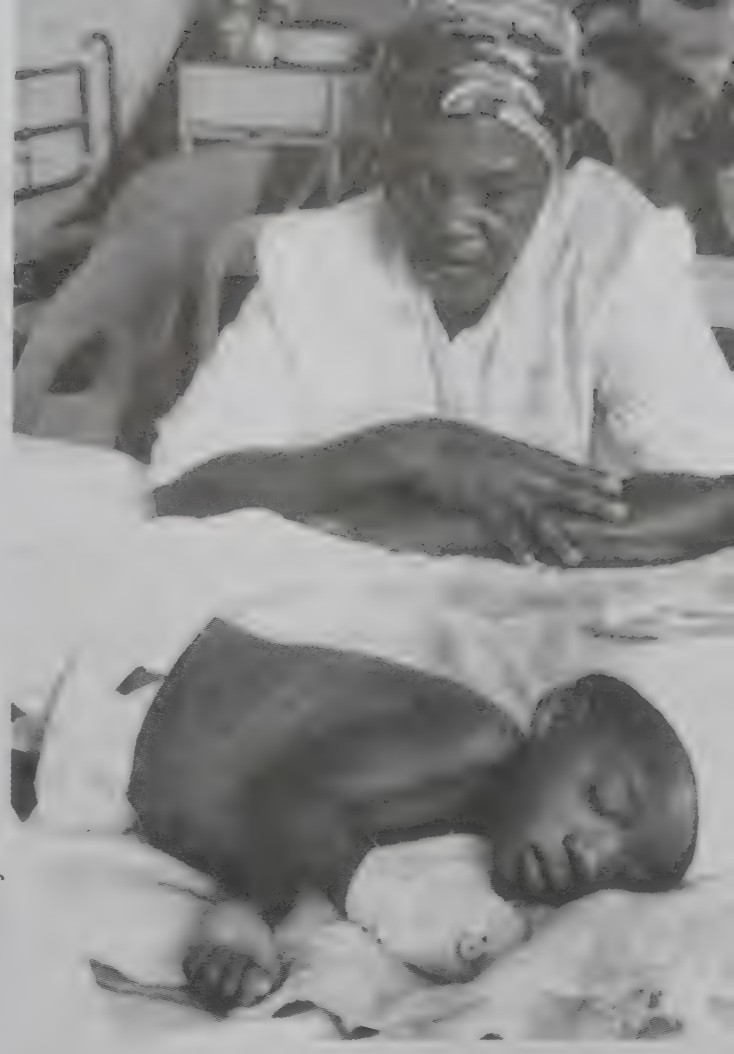
Edmund Dladla, national coordinator of the Botswana Network of People Living With HIV/AIDS, welcomed the president's leadership. 'Any person who is of working age, who has a job and some education talks about it. And everyone wonders about the impact AIDS is having, not only on those close to them, but also on the country as a whole. People are scared.'

'For a decade,' he continued, 'until the end of the 1990s, we were in a state of denial, blaming the crisis on foreigners. Then, as we realised its extent, we started acting. Today, I would say the government is very transparent, pro-active and accountable. We are the most advanced African nation in this struggle — and believe me, I would not have said that just three years ago.'

Employers get involved

Botswana's private sector has also become involved. Three years ago, the country's biggest employer, the Debswana diamond mining company, realised after testing its 6,000-strong workforce that fully a third of workers aged between 24 and 40 were HIV-positive. With revenues of some $1.8 billion dollars a year, and skilled miners scarce, the company set up its own HIV/AIDS scheme.

'We realised we had to do something fast because diamonds are the foundation of our economy,' said Tsetsele Fantan, director of the company's programme. She said Debswana agreed to provide free treatment for each infected employee and one legal spouse, while the government would provide treatment for other partners and their children. The government has also urged major banks, transport companies and even petrol stations to provide better levels of health care and make HIV counselling and treatment available to their employees.



Africa Recovery

Child AIDS patient in Botswana's Princess Marina hospital, which has the most advanced AIDS research laboratory in Africa.

The Harvard-Botswana lab is another example of the public-private partnerships the Botswana government is seeking to build. The government provided $3 million, while additional funding was contributed by the Gates and Merck Foundations, the Bristol-Myers Squibb drug company, the Harvard AIDS Institute and others.

'This collaborative programme is designed to demonstrate the benefits of a comprehensive, multi-sectoral approach to improving the care of people living with HIV in a country with limited resources,' said Dr. Clement Chela, of the Botswana Comprehensive HIV/AIDS Partnership. The fact that ARVs are now freely available, he added, has become a motivating factor for people to come forward. 'The programme we have put in place here can work in other countries in Africa, and with international financial help, it can be sustained.'

— *Africa Recovery* (September 2002)

Cuba's model in HIV/AIDS battle

Tom Fawthrop

Cuba remains an island in the Caribbean where the infection rate of HIV/AIDS (about half a million) is the highest outside Africa. Through drastic measures which were strongly criticised, Cuba managed to keep out the virus in the first years of the epidemic.

Cuba"s comprehensive approach to controlling the spread of HIV/AIDS has provided a rare success story in the battle against the global epidemic, but lingering controversy over past human rights violations mars its achievements.

Cuba has seen no dramatic increase in HIV transmission since the first case was diagnosed in 1986, and the country's HIV infection rate – 0.05% – is one of the lowest in the world and exceptional in a region with some of the highest infection rates in the world.

'Cuba was one of the first countries to take AIDS seriously as a problem, and provide a comprehensive response combining both prevention and care,' Peter Piot, executive director of UNAIDS, the umbrella AIDS organisation and a strong critic of Cuba's heavy-handed response of the 1980s, told a regional HIV/AIDS conference in Havana in April 2003.

When the first cases emerged, the government treated HIV/AIDS as a public health emergency: HIV patients were quarantined indefinitely and their sexual partners traced and tested; Cubans who had visited Africa were tested, as were pregnant women; HIV-positive women were given drugs to prevent transmission to their unborn children, their babies were delivered by caesarian section.

No anti-retroviral drugs were available on the island because of a US trade embargo. But in 2001 Cuban laboratories began manufacturing generic versions of six different drugs. Now it is one of a handful of developing countries that offer all its HIV/ AIDS patients a comprehensive supply.

Cuba set up a National Commission on AIDS to educate its 11 million people about HIV/AIDS in 1983 – three years before the island's first case was diagnosed. Today, Cuban health officials argue that their early response to AIDS was no different to that of South-East Asian governments who quarantined suspected cases of the respiratory virus SARS as recently as in 2003.

Some aspects of Cuba's broad development model, such as its emphasis on health and education, are held up by UN experts to other developing countries, including those in the Caribbean region, whose infection rate of 2.3% is the second highest in the world after sub-Saharan Africa (9%). Cuba's neighbour Haiti has an infection rate of 6.1%.

Dr Rigoberto Torres, director of the Health Ministry's HIV/AIDS programme, said: 'Cuba was one of the first countries to establish control and educational programmes. Our good educational system makes it easy. TV information ads teach people about AIDS and promote safe sex. We also have a sex education programme in schools.'

These days the government maintains a comprehensive database of those infected and their chain of sexual partners; and although patients are still required to attend an eight-week course in a sanatorium, HIV testing is no longer compulsory –though it is strongly recommended for pregnant women and those in high-risk groups.

Dr Byron Barksdale, director of the Cuban AIDS Project, an American charity, says: 'The US can learn a lot of things from Cuba about HIV/AIDS.' He told the annual meeting of the American Association for the Advancement of Science that the US too should educate people intensively if they are newly diagnosed with HIV infection.

'I don't know if six weeks or eight weeks are the magic numbers,' he said, referring to the education programme, 'but that is certainly a longer time than is given to people in the US who receive such a diagnosis. They may get about five minutes' worth of education.'

But he also admits to cultural differences between the two countries that would make it difficult to implement the Cuban model. 'In the US, the rights of the individual are foremost, but in Cuba the individual is expected to do what is necessary to protect the collective society'.

That is why people in high-risk categories are willing to roll up their sleeves and not protest HIV tests, he adds. In Havana the law is clear on both the rights and duties of HIV-carriers, and those suspected of being infected. Anyone who is HIV-positive, who does not use a condom and does not tell his/her sexual partner, commits a crime.

At the same time, says independent Cuban filmmaker Belkis Vegas, who is making a documentary on AIDS, 'Cuban law also prohibits discrimination: nobody can be fired from their job. Their salaries are still paid – even for the AIDS patients in a sanatorium.'

One such sanatorium, Les Cocos, is set amidst leafy parkland on the outskirts of Havana. The atmosphere was relaxed as doctors mingled with both patients and visiting relatives recently. Manuel Acosta and his wife Mayalin, both HIV-positive, choose to stay in Les Cocos rather than go home. Acosta

said: 'I'm comfortable here. Since I became HIV-positive, I have received training and now work as an x-ray technician. Food is free; it is much better than going home.' Since contracting HIV Mayalin has retrained as a nurse.

Dr Rivero Wong, who founded Les Cocos, still smarts from the old accusation that the sanatoriums forcibly detained AIDS patients and deprived them of their rights: 'It was never like a prison here and since 1993 all patients have been free to come and go as they please.'

The sanatorium is part of a nationwide AIDS awareness prevention campaign (APG), whose activists include 25 Les Cocos patients. One of them, Maria Elena Becquerm, a national coordinator of APG, says: 'We go into high schools and test them on what they know about AIDS; the need for condoms. Latin people don't like to use condoms but we try to change their habits.'

With 47% of HIV patients choosing to stay on in sanatoriums once their education course is over, the APG also runs a confidential AIDS hotline for those outside.

'Cuba has a lot of potential and lots to offer others grappling with the AIDS epidemic,' says Nina Ferencic, UNAIDS programme development adviser for the Americas. But, she adds, it is largely up to individual countries to decide how they want to apply the model.

For its part, Cuba has offered to produce anti-retroviral drugs for poor countries if another country agrees to finance production at cost price. Two developed countries – Britain and France— are reported to have shown some interest in collaborating with the proposed project.

But Torres is unimpressed. 'In coping with the global AIDS crisis, the most serious problem is the lack of political will,' he says. 'I think it has been a very poor response from rich nations on Cuba's offer to combat AIDS in other countries.'

— Panos Features

Tom Fawthrop is a British freelance journalist based in South-East Asia who writes for the *Economist, BBC Online* and London *Sunday Times*. He has visited Cuba five times to research its health system.

Haiti: Fighting AIDS through community healthcare

Anne-Christine d'Adesky

Poor people with AIDS don't have to die when there are drugs which will save their lives. The work of one rural clinic proves it.

Nacla

Haiti's people plagued by poverty, malnutrition, illiteracy and low wages.

For the majority of people heading for the village of Cange in Haiti's high, forested interior there is little choice in making the journey. They and their family members are sick, desperate and penniless. Many have tuberculosis and HIV. They leave their mud shacks in the mountains to journey to the *Zanmi Lasante* (Creole for 'Partners in Health') medical complex. They arrive at all hours of the day or night, some shouldering dying relatives on hard wood pallets like an awkward religious cortege. At dawn, dozens are camped out, waiting to be seen by the clinic's small staff.

The *Zanmi Lasante* clinic was started by a group of activists led by Dr Paul Farmer, a gangly American doctor and anthropologist from Harvard who views health as a fundamental issue of human rights. Farmer came to Haiti in 1983. His vision was a medical centre that could provide care to rival a rich place like Harvard, but one that was rooted in community ownership. He benefited from the commitment of Père Fritz Lafontant, a well-respected Episcopal priest who mobilised community support for the project.

With several friends, Farmer founded Partners in Health (PIH) as a small non-profit organisation that now sponsors the Cange clinic and similar projects in Peru, Mexico, Cambodia and Roxbury, Massachusetts, a poor Boston neighbourhood. Today, PIH's modest staff at Cange provides care for up to a million people, including 100,000 in the area. Fees for health services are nominal or free.

Over the past year, Farmer and his team have put Cange at the centre of the international AIDS map and fuelled a passionate debate among public-health policy makers. His team is determined to prove that it is possible not only to treat the poorest Haitians with HIV/AIDS using expensive antiretroviral (ARV) combinations but also to offer a community-based model of HIV care that could be applied in other poor countries. They advocate a strategy of Directly Observed Therapy (DOT) that his team has perfected against multidrug-resistant tuberculosis (or MDR-TB). If it can be done in Haiti, they argue, it can be done anywhere.

Haiti is among the poorest countries in the world, with a per-capita income of barely $400 and an unemployment rate over 70%. Most Haitians live in rural areas as

sharecroppers working infertile land.

PIH has been battling AIDS in Cange since 1986. Staff began administering AZT to pregnant women in 1995, with great success. In 1997, the so-called 'triple cocktail' was first offered to exposed health workers and victims of rape. But the chief treatment lesson has come from drug-resistant tuberculosis, a chronic illness.

Although TB is clearly different from AIDS, it shares certain features that pose a tremendous challenge to daily and long-term management. Both diseases require patients to take several drugs daily and to substitute second-line drugs to overcome cases of drug failure and drug resistance, including

Africans adhere to better treatment

Donald G.Mcneil Jr.

Contradicting long-held prejudices that have clouded the campaign to bring AIDS drugs to millions of people in Africa, evidence is emerging that AIDS patients there are better at following their pill regimens than Americans are. Some doctors, politicians and pharmaceutical executives have argued that it is unsafe to send millions of doses of antiretroviral drugs to Africa, for fear that incomplete pill-taking will speed the mutation of drug-resistant strains that could spread around the world. The danger already exists: nearly 10% of all new HIV infections in Europe are resistant to at least one drug.

For Africa, the issue is particularly touchy because it is tinged with racism. In 2001, for example there was an outcry when the director of the United States Agency for International Development said that AIDS drugs 'wouldn't work' in Africa because many Africans don't use clocks and 'don't know what Western time is'. Now surveys done in Botswana, Uganda, Senegal and South Africa have found that on average, AIDS patients take about 90% of their medicine. The average figure in the United States is 70%, and it is worse among subgroups like the homeless and drug abusers.

Compliance has become easier because drug makers from India and elsewhere are beginning to make triple-therapy cocktails that come in as few as two pills a day. (These are not available in the United States yet because of patent problems – no Western company makes all three drugs for an ideal cocktail.) After nearly a decade of watching Africans die because AIDS drugs cost US$10,000 or more a year per patient, rich nations began pledging aid after generic competition in 2001 drove prices down to about US$300 a year. At the end of August 2003, the World Trade Organisation (WTO) agreed to alter its rules to give poor nations more access to life-saving medicines.

But as with any epidemic moving through a poor and ill-educated populace, the threat of disaster clings like a shroud. Patients in badly supervised programmes have been caught selling pills or sharing with desperate relatives – acts of greed or mercy that could lead to doomsday strains of the virus. Anti-retroviral therapy 'is the No. 1 priority for the developing world', said Robert C. Gallo, director of the Institute for Human Virology and a pioneer in researching HIV, the virus that causes AIDS. 'But it will be a tragic mistake if it's not done right. You'll have "Eureka!" "Thank you, America!" for two or three years – but then you'll get multi-drug resistance, and whoops...' Drug-resistant strains are inevitable, doctors say, and turn up in every illness from malaria in Africa to children's ear infections in Manhattan.

Hard-to-cure variants evolve spontaneously in response to drugs. But they are more likely to grow and be passed on if patients skip doses, because triple therapy often suppresses even mutant strains. To avoid an epidemic of incurable AIDS, new drugs must be discovered faster than old ones become useless. Africa can still do better than the West, they say, by avoiding old mistakes. Today's drugs are more potent and no one will spend years on one drug, thereby breeding resistance, as many Westerners did on AZT before triple therapy emerged in 1996. Moreover, doctors say, most African patients are zealous about their regimens. They are also more truthful when estimating their adherence, said Dr. David Bangsberg, a professor of medicine at the University of California in San Francisco who has studied compliance patterns here and abroad.

On average, he said, American patients tell their doctors that they are doing 20 percentage points better than they really are – that is, a patient who says he takes 90% of pills will, when tested with unannounced home pills counts or electronic pill-bottled caps, turn out to be taking 70%. A study of 29 Ugandan patients found that, on average, they estimated that they were taking 93% of pills and proved to be taking 91%.

Though poor, more than 80% of the Ugandans had jobs, though most earned less than US$50 a month. Most were women in their 30s, and paying US$27 a month for their twice-a-day, three-drugs-in-one pill called Triomune, made by Cipla Ltd. of Bombay. In many such cases, explained Dr Merle A. Sande, a University of Utah medical school professor who also works in Uganda, the whole extended family, possibly with several infected members, will chip in so that one member will be saved to care for the children 'If the whole family is pooling its resources to pay for you,' he said, 'you damm well better take your drugs.'

'That's a whole different scenario from the US, where patients get free medicine, and if they change therapy, will let a month's worth go to waste.' Several doctors in Africa said their patients were highly motivated because they had seen friends or family die. Most come in only when deathly ill, so the drugs seem to perform a miracle, making them well enough to go back to work. And even US$1 a day is a lot, so they treat it as 'an investment', said Dr. Elly Katabira of Makerere University Medical School in Uganda.

In Botswana, with the world's highest infection rate pill counts on 400 of the 10,000 patients on therapy showed that 85% were taking their pills flawlessly, said Dr. Ernest Darkoh, the national program manager. If you loosen the criteria a little – missing a dose by two hours, for example – you get about 90%,' he added. There are a few exceptions, he admitted: 'Some people bring back their pill containers saying, "Thank you, but my traditional healer told me not to take these".' However, some programmes are not as good as others. In Nigeria, Africa's most populous country, an ambitious, widely praised plan to get generic drugs to 15,000 citizens has been hampered by bureaucracy, corruption and a scarcity of laboratories.

— *The New York Times*

Nacla

Almost 80% of the population is illiterate.

multidrug resistance. A key difference is that resistant TB can be cured, whereas HIV therapy is viewed as a lifelong maintenance regimen. The longer patients must take drugs, the greater the chance of resistance developing, which makes MDR-HIV a real threat.

That's why some critics claim that antiretroviral therapy is inappropriate in poor countries. They argue that, aside from the cost, it's just too hard without an adequate health infrastructure and trained professionals. They worry that mass introduction of HIV medications in poor countries will lead to new drug-resistant strains that will make it harder to treat AIDS in the future.

Although he admits that drug resistance is an issue, Paul Farmer belittles these concerns. The PIH initiative is called HIV Equity, for good reason. Farmer believes the fight for access to HIV drugs is fundamentally one of justice.

'The people who say you can't treat the poor with these drugs are just looking for a reason not to do it,' said Farmer, taking square aim at what he calls the heart of the problem: greed and indifference.

'It's amazing how many excuses people can come up with when they don't want to do something. The bottom line is that rich countries and governments don't want to pay for poor people. I'm not saying HIV/AIDS isn't a complex medical disease - it is, but it can be managed with existing medicine and using DOT.'

The HIV Equity project began in 1998 when ARV drugs were offered to several patients with severe AIDS who no longer responded to treatment of their opportunistic infections. Today, 65 people with advanced AIDS are receiving what Haitians call *tritherapie*. There is a very long waiting list. Almost 4,000 people from the area have HIV and Farmer estimates that 10% might be sick enough to qualify for treatment.

Within a short period, most patients on triple therapy feel better and begin to gain strength. With few exceptions, the patients tolerate the regimens well and adhere to their medication. Initial drug-related side effects like vomiting are so far minimal and easily managed.

Teofa, née Bernardin Gracia, nods when he hears this. A 32-year-old man who looks 18, he was frail and unable to work when Farmer found him. Like his neighbours, he had heard about AIDS and knew about condoms, but he regarded the epidemic as a distant threat. He had no idea HIV was the cause of his illness.

'The drugs we take for HIV, they are so important we don't even think of them as drugs, but as something God has brought us,' Teofa says passionately.

'There are a lot of people who say: "In such a small, poor country you can't get those drugs, you can't manage them." But for me, it's not true. We are the evidence of the success. There is poverty and we are poor, but that's not a reason to say we can't manage a big thing like this. And if we succeed, it shows all of us can manage this.'

— New Internationalist

Anne-Christine d'Adesky is a freelance journalist living in Los Angeles. She is a former editor of *HIV+ Magazine*.

Africa needs aid from rich to fight AIDS

Health ministers from several African countries while in Rome called on wealthy countries to provide more assistance to deliver 'high quality' drug treatment for individuals living with HIV/AIDS and called on pharmaceutical companies to lower antiretroviral drug prices 'to the point of being compatible with the weak resources of our countries', *Agence France-Presse* reports.

Health ministers from the Central African Republic, Congo, Ivory Coast, Ethiopia, Liberia, Malawi, Mozambique, Senegal, Sudan, Tanzania and Togo released a statement saying that treatment for HIV/AIDS should be considered a human right.

'AIDS is affecting the entire planet, but currently 70% of its victims die and are born in Africa,' the statement said, adding that the most developed countries should 'mobilise economic and human resources to bring a halt to this extermination'.

Only 3% of the 3.9 million HIV/AIDS patients in Africa who could benefit from antiretroviral drugs have access to such treatment.

— kaisernetwork.org

Brazil protects public health with free HIV/AIDS drugs

Thousands of people across the South can't afford to buy AIDS drugs. But not in Brazil. *MATTHEW FLYNN* describes how one country fought back.

Nearly a decade ago, the World Bank warned that Brazil would have over a million AIDS cases by the turn of the century if action were not taken. Today, while the country has lost 100,000 people to the deadly virus, infection rates remain a low 0.6% and the predicted epidemic has been avoided.

Prevention is one of the pillars of Brazil's successful AIDS programme. But treatment and human rights are also key.

Brazil began investing in drug therapies in the early 1990s, even though aid agencies argued that drug therapy was not 'cost effective' and that scarce resources should be concentrated on prevention.

But, says Paulo Teixeira, head of the government AIDS programme, the Brazilian thinking was different: 'It is impossible to mobilise a society, to mobilise people – infected or not – for a national effort if you do not provide what they are expecting to receive: support and clinical treatment.'

Brazil's commitment to providing affordable drug therapy is abundantly clear. In 2001, the Health Ministry distributed antiretroviral (ARV) drugs to 110,000 registered HIV patients – free of charge.

'Access to free medication encourages more people to test themselves and helps curb the spread of the disease,' explains Veriano Terto, general co-ordinator of the *Associação Brasileira Interdisciplinar de AIDS*. ABIA is a non-profit organisation which conducts research and provides counselling to HIV-positive people.

Terto, who learned that he was HIV-positive in 1996 and began treatment the following year, says that in a developing nation like Brazil drug therapy needs to be available and affordable.

'Like most other Brazilians I would not be able to afford the high price of the medication.' Since learning of his illness Terto has been able to continue working normally and was able to finish a doctorate in public health.

Like other cash-strapped developing countries, Brazil was faced with the problem of providing a growing number of AIDS patients with expensive treatments sold only by large, international drug companies.

Brazil's answer: manufacture the drugs locally

'We started producing those drugs before the country signed the WTO Trade Related Intellectual Property agreement (TRIPS) in 1996,' recalls Teixeira. 'The first consequence was that the price dropped tremendously – some 80%.' While treatment in the US costs $12,000, in Brazil it is $2,500 and falling. With most ARVs already on the market before the country adjusted its patent laws to WTO requirements, Brazil could sidestep steep royalties to the companies when making generic copies.

Government labs currently produce 8 of the 14 ingredients that make up the so-called AIDS cocktail. The government saves $250 million a year by not paying for the high-priced, patent-protected imported drugs, and it avoids the additional expenses of hospital care for untreated patients.

'The reduction in the incidence of AIDS-related diseases has saved us $670 million over three years,' reports Dr Marco Antônio Victória, chief medical adviser to Brazil's AIDS programme.

Big Pharma reacts

Government participation in Brazil's $6.5 billion domestic drug market was not cheered by everyone. The giant multinational companies, collectively known as Big Pharma, were angered by the cheaper, generic drugs. More recently, their ire has focused on government research into newer ARV treatments. Unlike generics, Efavirenz (sold by Merck) and Nelfinavir (made by Hoffmann-La Roche) are protected by Brazilian patent legislation.

The US, pressured by Big Pharma, threatened a WTO investigation of Brazil's breach of the TRIPS accord. But unlike smaller nations that often back down in the face of pressure, Brazil rallied international support for its case. Both the UN Commission of Human Rights (UNCHR) and the World Health Organisation (WHO) approved Brazilian-sponsored motions supporting access to life-saving drugs as a basic human right.

The country then scored another small victory at the WTO's annual meeting in Doha, Qatar in 2001 where the US — partially owing to the Anthrax scare — offered lukewarm support to a similar measure.

Meanwhile, the government lab FarManguinhos was diligently working to crack the secret of Efavirenz and Nelfinavir.

After learning how the drugs were manufactured, Brazil would be in a position to threaten to break their patents and produce them locally – or negotiate better prices with suppliers Merck and Hoffmann-La Roche.

Eloan Pinheiro, director of the state-owned FarManguinhos lab, adds that after discovering the

make-up of a drug it is possible to compare the cost of production to the retail price. 'It was easy to calculate the profit margin. It was enormous and continues to be exorbitant,' she says.

With the drug companies stripped of their clothes, the Health Ministry negotiated price reductions of 58% for Nelfinavir (from $1.53 a capsule to $0.65) and 64% for Efavirenz (from $2.32 a capsule to $0.84).

Despite the success of Brazil's generic programme, it is far from perfect. The country has 110,000 HIV-positive patients who receive the drugs, but another half-million people are estimated to be infected who don't benefit from government programmes.

'We still have AIDS being contracted by socially excluded, more marginalised people,' says Veriano Terto of ABIA. 'And while the conditions of poverty, unemployment and violence that create such marginalisation are not combated, it will be difficult to control the spread of AIDS in these populations.'

Brazil remains a highly stratified society and its public-health system continues to be underfunded. But whatever its shortcomings, the country has made significant progress despite limited resources.

In fact, one of Brazil's newest exports is its expertise in dealing with HIV/AIDS. Médecins Sans Frontières (MSF) recently signed an agreement with FarManguinhos to use their generic antiretrovirals in MSF projects. In return, MSF helps fund FarManguinhos' efforts to find new cures for diseases ignored by Big Pharma.

Brazil has also signed technical co-operation agreements with four African countries – Angola, Mozambique, Guinea Bissau and São Tomé. And several others, including Namibia, Zimbabwe, South Africa, Kenya, Nigeria and Botswana, are said to be interested in the country's AIDS drugs.

— New Internationalist

Matthew Flynn is a freelance journalist based in Brazil. He is researching Brazilian industrial policy at the Universidade de São Paulo.
matthew.flynn@journalist.com

US free trade agreement threatens health services and HIV/AIDS patients' rights in Southern Africa

Patrick Burnett

On 4 November 2002, United States Trade Representative (USTR) Robert Zoellick formally notified US Congressional leaders of President Bush's intention to initiate negotiations for a free trade agreement (FTA) with the Southern African Customs Union (SACU), which includes Botswana, Lesotho, Namibia, South Africa and Swaziland. These negotiations are now underway, with the next round scheduled for 23 February 2004 in Namibia. As far as we are able to ascertain, the negotiators plan to conclude their discussions in or around October 2004, with a US-SACU FTA being signed before the end of the year.

The Treatment Action Campaign (TAC) and the AIDS Law Project (ALP) believe that trade between nations, when conducted within the framework of a reasonable and fair set of rules that adheres to the triple-bottom line of environmental, social and commercial sustainability has the potential to act as a tool for attaining developmental priorities. Our support for the ongoing negotiations would therefore be predicated on the agreement strictly adhering to these principles. Yet the US position, as clarified in Mr Zoellick's correspondence with Congress, raises cause for concern.

In his letters to the Speaker of the House of Representatives and the President of the Senate, Mr Zoellick set out reasons for entering into such negotiations, as well as the USTR's 'specific objectives for negotiations with the SACU countries'. In particular, Mr Zoellick raises the following US objectives:

'We plan to use our negotiations with the SACU countries to address barriers in these countries to US exports - including high tariffs on certain goods, overly restrictive licensing measures, inadequate protection of intellectual property rights, and restrictions the SACU governments impose that make it difficult for our services firms to do business in these markets. We also see the negotiations as an opportunity to advance US objectives for the multilateral negotiations currently underway in the World Trade Organisation (WTO)'. In our view, a number of the specific objectives identified have the potential to undermine the financing and provision of health care services in SACU countries, both in the public and private health sectors, as well as the rights of people living with HIV/AIDS. In particular, if translated in binding commitments, many of these objectives have the potential to limit the ability of the South African government in discharging its constitutional obligations, primarily in respect of the right of access to health care services. In our view, such undertakings would be an unconstitutional exercise of power.

The ALP and TAC are concerned that the US/SACU FTA negotiations have the potential to result in binding commitments on SACU member states that undermine access to health care services, the rights of people living with HIV/AIDS and the ability of such states to comply with their domestic, regional and international human rights obligations. In our view, such an agreement would not only unlawfully conflict with certain national constitutions and human rights instruments, but would also serve to advance the interests of the US at the expense of the health and welfare of the people of Botswana, Lesotho, Namibia, South Africa and Swaziland.

— Equinet News

EQUINET News is a monthly newsletter on the struggle for equity in health. It is published by *Fahamu* for the Network for Equity in Health in Southern Africa.

http:/www.equinetafrica.org/newsletter

HIV/AIDS is a development issue

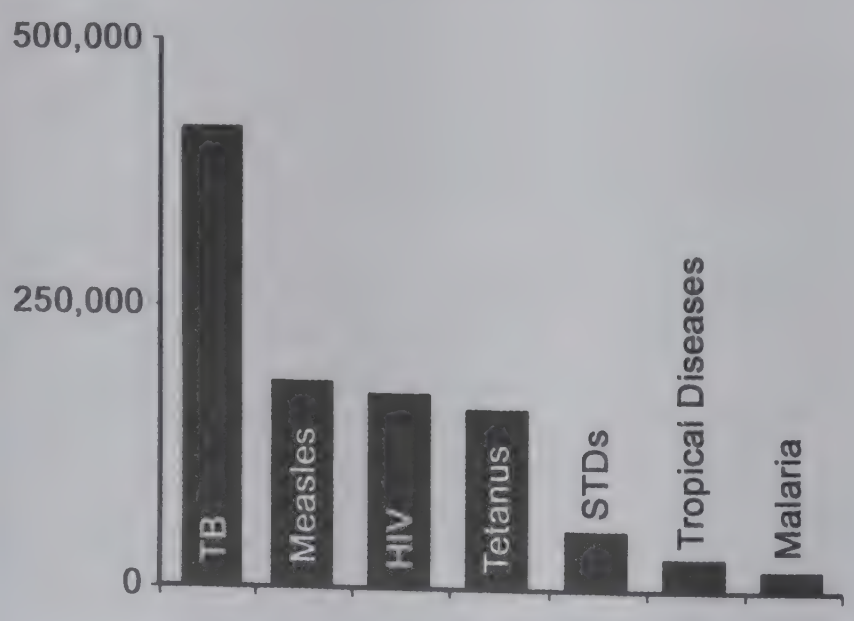
In India, where diseases of poverty are the major causes of death and morbidity, the HIV/AIDS epidemic has to be seen as part and parcel of the other pressing health problems and the social conditions that give rise to them. Well-funded health programmes ignore this with selective vertical programmes that are costly and ineffective and do not benefit the real stakeholders. *DR. HARI M. JOHN* takes issue with such initiatives and suggests an integrated approach in eight priority areas when dealing with the HIV/AIDS epidemic in India.

Not for a moment am I downplaying HIV/AIDS as a public health threat either in India or elsewhere. Statistics, research and case studies from sub-Saharan Africa, especially from South Africa and Zimbabwe, have shown the devastation that can be brought by HIV/AIDS when it attains epidemic proportions. But as far as India is concerned, let us keep things in perspective.

I want to place for your consideration the enormity of the health problems faced by the people of India because of tuberculosis, malaria and poverty. Tuberculosis alone kills close to 500,000 people in India, more than 1,500 people a day, about one person a minute (see chart below).

TB is a leading killer of adults

Estimated HIV deaths as compared to other diseases, India, 1999
– National Tuberculosis Control Programme, India



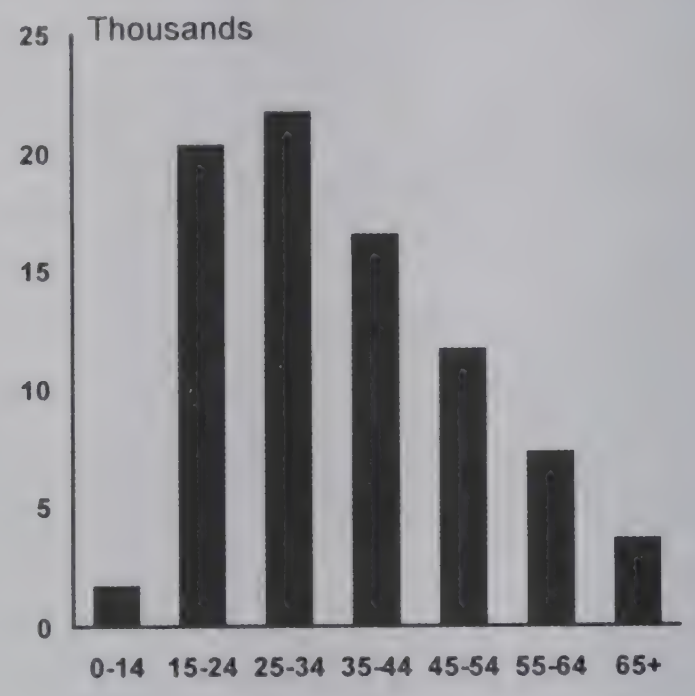
♦ TB kills more adults than any other infectious disease

♦ Because it affects adults, TB causes enormous social and economic disruption

♦ The burden of TB is enormous but is hidden by stigma

TB affects young adults most

Age groups affected by TB, India, 1993-1999
— National Tuberculosis Control Programme, India



♦ TB may create more orphans than any other disease

♦ Recent studies suggest that every year in India more than 300,000 children leave school on account of their parents' TB

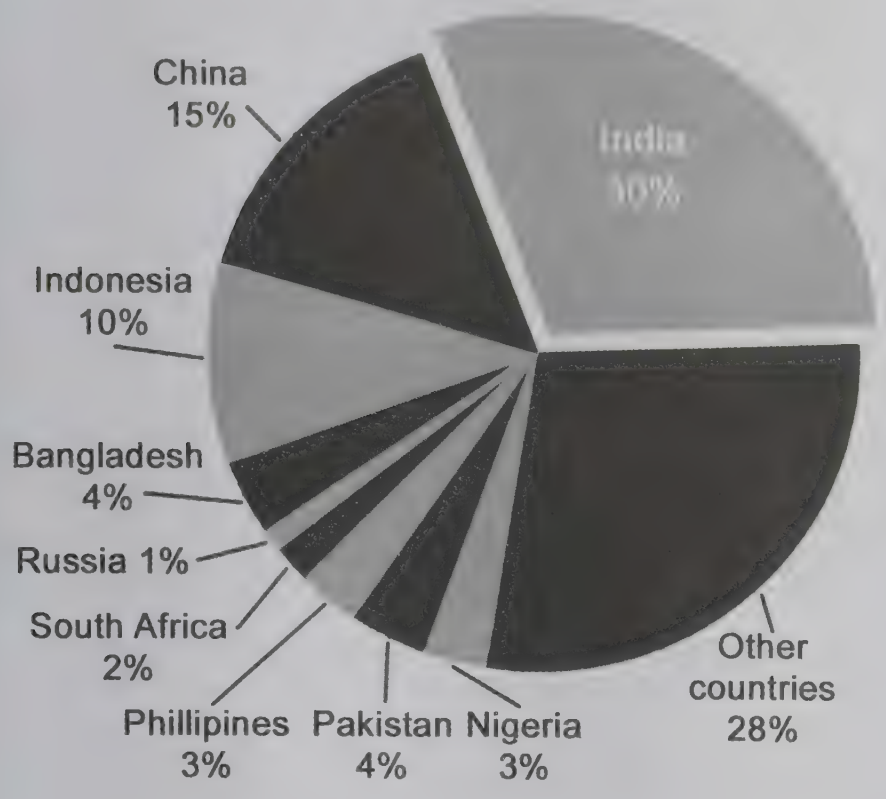
In India, children and young adults in the productive age group of 15 – 54 are selectively affected by TB. When such a large population is thus affected, there are enormous economic implications for the country.

India accounts for nearly one third of the global TB burden

♦ India has more cases of TB than any other country in the world and twice as many cases as China, which has the next highest number

♦ Although exact and current information on TB incidence and prevalence is not available, studies show an incidence rate of more than 200 per lakh, among the highest in the world (1 lakh = 100,000).

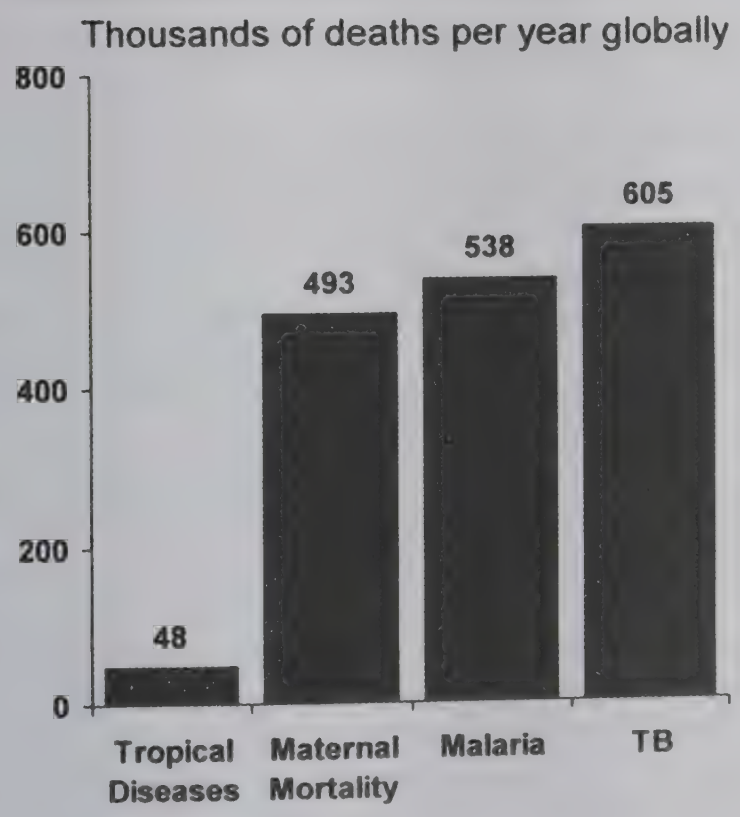
Global TB burden: India's share
— National Tuberculosis Control Programme, India



India has the highest number of TB patients and more than twice the number of the next highest country, China. The very high incidence rate is a commentary upon not only the socio-economic status of the vast Indian majority, but also on the so-called public health system in India and the vertical programme called the National Tuberculosis Control Programme.

TB is a leading killer of women in India

The leading global killers of women



♦ TB kills more women in India than any other infectious disease

♦ TB kills more women than all causes of maternal mortality combined

♦ Women with TB are often severely stigmatised

A recent study in India done by the Ministry of Health says that more than 100,000 women are rejected by their families each year on account of TB. India has a Maternal Mortality Rate of 570 and at any given moment in time, more than 80% of pregnant rural women are anaemic. There are abortions induced and spontaneous. But deaths due to all these causes are lower than deaths due to TB alone.

Diseases of poverty

♦ In the world today, 940 million suffer from hunger and two billion are malnourished

♦ Seventy percent of the poor are Asians and half of the developing world's poor live in South Asia

Worldwide two billion people, one third of humankind, live in poverty. A great majority of them are our compatriots from South Asia. Poverty leads to a person's or community's exclusion from the mainstream way of life in a society. We in India know very well who is excluded – the Dalits, the landless, the indigenous peoples and among them, selectively, women.

Distribution of the world's poor, 1985 – 2000 (in millions)

Region	1985	1990	2000
All developing countries	1051	1133	1350
South Asia	532	662	945

World Development Report 2000

Worldwide, poverty levels have increased in absolute numbers since the implementation of structural adjustment programmes and the introduction of neoliberal economic policies (see table above).

i) Malnutrition

♦ More than half the world's malnourished and under-weight children live in South Asia. South Asian countries carry the double burden of disease and poverty, establishing a seemingly vicious cycle of disease-low productivity-poverty-disease.

This is the result of a combination of factors, many of them related to caste which gave rise to class differences and the large number of landless peasants; and the benign and often malignant neglect by the ruling classes of the poor and marginalised. Half the world's malnourished children live in South Asia.

ii) Death from diarrhoeal diseases

♦ About 6,000 children, the equivalent of 18 fully loaded jumbo jets, die EVERY DAY from diseases associated with lack of access to drinking water, inadequate sanitation and poor hygiene

Disaggregated rates will perhaps show that girl children are more adversely affected than boys, we being a son-preference country. Such rates will also

show that vastly more children of the lower castes living in rural areas and children of the landless peasants die than those with upper caste, educated, urban parents. Vastly many more die from diarrhoeal diseases than from HIV/AIDS.

♦ According to the *Lancet*, nearly 11 million children do not live to see their fifth birthday each year due to a lethal combination of malnutrition and mostly preventable diseases – a catastrophe that experts say is needless.

♦ Just six countries (in order of numbers) – India, Nigeria, China, Pakistan, the Democratic Republic of Congo and Ethiopia – suffer 5.5 million child deaths a year.

Resurgence of malaria

♦ Malaria, which declined in the sixties, has made a strong comeback in India. Malaria appears in epidemic form in many states even after 40 years of the implementation of the National Malaria Control and Eradication Programme.

♦ Malaria deaths are on the increase due to an increase in *Plasmodium falciparum* cases.

♦ There are close to 500 million (a twelfth of humankind) clinical cases of malaria that occur worldwide, while some 2.5 million die from the disease each year. When one in twelve individuals is sick in the world with malaria, there will be a drastic impact on the economy, society and family.

As can be seen in India, diseases like tuberculosis, malaria, typhoid, infective hepatitis, malnutrition and anaemia, singly and together, have much greater consequences – social, economic and political – than HIV/AIDS alone. These diseases are linked to poverty just as HIV/AIDS is now recognised as a disease of poverty.

In 57 years since Independence, the public health system in India, the private health system, the NGO health system and the church health system together have scarcely made a dent in the existing illness pattern of the poor. What went wrong?

Selective primary healthcare

Twenty-five years back, the principles of comprehensive primary health care (PHC) were enunciated at Alma Ata. However, active undermining of those principles in the name of vertical, top-heavy, cost-ineffective programmes called selective primary health gave a quiet burial to PHC.

There is now a very wide disparity in health status between the rich and the poor, between the urban and the rural, between the educated and the uneducated, and between the upper and lower castes. This is taking place everywhere in the world.

In India the already weak public health system has been further weakened by the dictates of the IMF/World Bank and the globalisation processes manifested in the reduction and withdrawal of subsidies in public health. There is now a resurgence of long-forgotten diseases such as leptospirosis and leishmaniasis on the one hand and the resurgence, in virtually untreatable forms, of tuberculosis and malaria, not counting malnutrition and hunger, on the other.

This being the case, and knowing that vertical programmes have failed in the past, why are we involved in such programmes? Because there is money in it? Because our partners want us to? Because the priorities are decided by the health decision-makers in the West?

HIV/AIDS: Who are the stakeholders?

One would expect those living with HIV/AIDS to be the primary stakeholders. But consider this: Indian drug companies CIPLA and Ranbaxy can make antiretrovirals available for less than $1 a day while the American pharmaceutical industry charges almost $100 a day. Who is the stakeholder here? Who is making money?

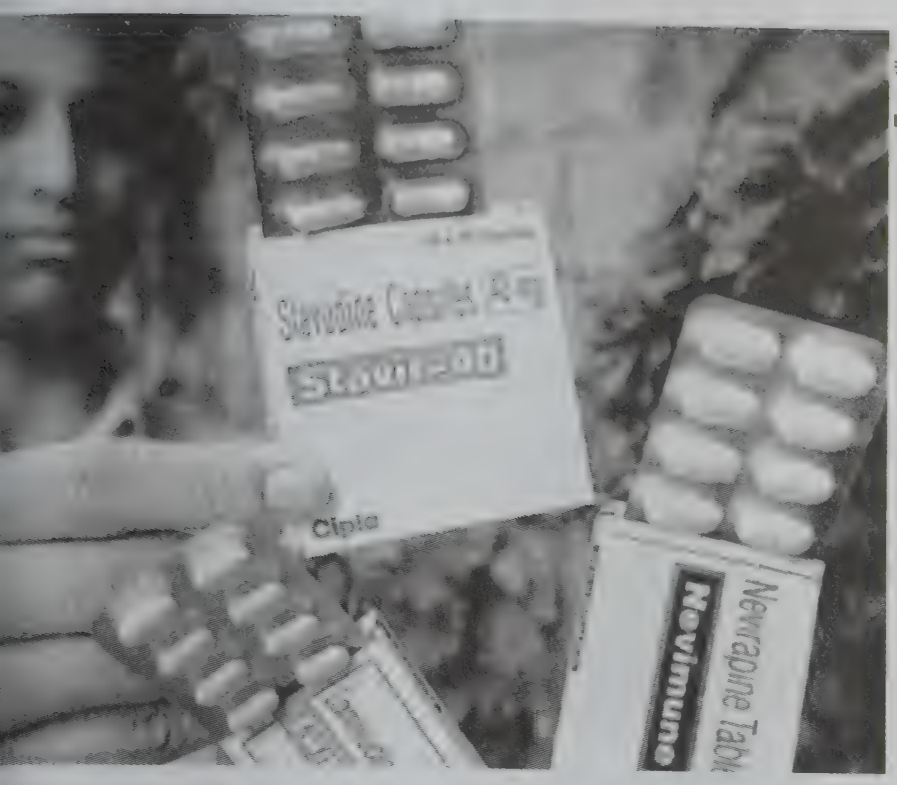
Consider this too: Because of WTO stipulations which we are party to, beyond January 2006 when TRIPS comes into force in India, CIPLA and Ranbaxy will not be allowed to manufacture these drugs. (There are loopholes that we can exploit such as compulsory licensing and parallel imports, which Malaysia has successfully used recently.) So who is the stakeholder here? Obviously the industrialised countries and their pharmaceutical industry.

When large amounts of money, in the millions of dollars, are made available for any programme, what do governments do? Set up airconditioned offices to administer these funds and oversee the programme, build up costly infrastructures, buy vehicles, hire a large staff and have highly paid consultants – all in the discredited vertical programme mode, leaving very little for the actual programme and those living with HIV/AIDS. (A government estimate states that only 19 paise of every rupee allotted to the poor actually reaches them!) So, who is the stakeholder here?

Corporate stakeholders

As famously said by Jeffrey Sachs in another context, the person living with HIV/AIDS is, who should be the primary and perhaps the only stakeholder, is considered an economic burden and her illness a loss of productivity. In the complex web of stake holders in this scenario, all the other stakeholders mentioned above, along with the syringe makers, diagnostic kit makers, the retail pharmaceutical industry, the medical profession, the health workers and providers, have disproportionately higher stakes than the poor person living with HIV/AIDS.

If the World Health Organisation is a stakeholder, what were they doing when western drug companies and industrialised countries were holding African nations to ransom? It is the grit of South Africa which went to court and the numerous HIV/AIDS activists who raised the consciousness of the people and decision-makers around the world, as well as the Indian drug companies which played a crucial role while WHO gently slumbered. WHO's 3 x 5 programme (three million people to be targeted with antiretrovirals by 2005) is still a theoretical prescription and, if implemented as a vertical programme, is designed to fail.



Frontline

Treatment with anti-AIDS drugs is only part of the solution.

Is the Government of India a stakeholder? A full seven years after antiretrovirals became virtually universal in the west and two years after South Africa succeeded, and given the fact that India produces the cheapest drugs in the world, till today, the government does not provide treatment. Their contempt for the public's health, in any case, was demonstrated when they made a film actor with no known experience of any kind other than acting the Health Minister for a billion people three years back. Mercifully he is not there anymore but the same somnolence on the part of the rulers continues while HIV/AIDS threatens to become a pandemic.

Do we expect the government to do much about this? What, really, can people expect of a government that has reduced expenditure on health from 1.4% of the GDP in 1991-92, one of the lowest in the world already, to 0.9% in 2001-02? They have passed laws for the benefit of the ruling classes; reduced taxes for the rich; removed subsidies on public systems such as in health, education and public distribution; reinforced the dictum that the ruling classes, of whatever ideological persuasion, rule primarily for their own benefit.

NGOs as stakeholders: their role in fighting HIV/AIDS

There are eight priority areas in which NGOs have been involved and should continue their involvement:

♦ *Water and sanitation*

Currently (according to official figures) 70% of rural and 85% of urban households have access to potable water. (In a large city like Chennai, we do not have piped water this year!) 46% of urban and 17% of rural households have access to sanitation. Keep in mind also that garbage collection is being privatised and water is being privatised (Vivendi). Bear in mind that 80% of illnesses are water-related.

♦ *Food security and nutrition*

Forty-five million tons of food grains are in stock but there is sub-nutrition, under-nutrition, not to speak of well-documented starvation deaths in many states. Three hundred and sixty million people are not able to achieve the minimum nutritional levels – one third of infants are born with low birth weight because of poor maternal nutrition; 53% of children under five are malnourished.

♦ *Primary education*

Universalising primary education is the key to solving many of the issues such as child labour, malnutrition and drug abuse. (The current literacy rate is 64% for males and 39% for females.) Access to education and retention of students, especially girls, without dropping out is important.

♦ *Health of women and children*

Infant mortality, under-five mortality and maternal mortality are still unacceptably high in a country that has put its own satellite in space and is bidding for the Olympics. Disaggregated data show it is the outcastes and the landless who contribute the most to these statistics.

♦ *Employment*

A recent UNDP report states that the present pattern of growth in India is 'jobless growth' where economic growth does not result in opportunities for employment. In spite of the recent spate of advertisements by the government, India shines for perhaps 15% of their citizens who also experience a 'feel good factor'. The projected economic growth rate is 8.5% but employment lags behind at 2%. Ways must be found to generate employment in the formal and unorganised sectors as well as improving working conditions.

♦ *Gender equality*

Our gender inequality is reflected in the adverse sex ratio of 927 females for 1,000 men, among the lowest in the world, a shameful thing indeed. Girl children are routinely and severely discriminated against throughout their lives. Women and girls suffer from a low status in society and consequently a low self-image. Feminisation of poverty is a trend all over India.

♦ *Population stabilisation*

1.1 billion people and still growing! It will be around 1.45 billion by 2015 before declining.

♦ *Environment*

The pressure of human lives on the environment is overtly visible throughout India, with problems of air and water pollution, solid waste mountains, every small town strewn with plastic bags, deforestation (that has left Cherrapunji, the rainiest place on earth, waterless!), overexploitation of natural resources, floods, soil erosion, and sedimentation of water sources. All these have affected living conditions, health, productivity and other socio-economic conditions.

Therefore, HIV/AIDS is not merely a health issue. It is a development issue and needs to be understood from a broader social and economic perspective. To deal with the epidemic, future programmes will need to deal with the abovementioned eight priority areas, especially with gender and economic imbalance, social and economic marginalisation, and look at ways to stimulate the development of new community responses.

Dr. Hari M. John is with the ANITRA Trust, Chennai.

Controlling the epidemic in India

Asha Krishnakumar

Spreading awareness about HIV/AIDS will go a long way in correcting the existing misconceptions and removing the stigma associated with the disease in India.

Chamundeswari, 23, is HIV-positive; so are her two children aged four and two. Her husband, Rajan, died last year at the young age of 26 of acquired immune deficiency syndrome (AIDS). Chamundeswari got infected by Rajan, who had tested positive for human immunodeficiency virus (HIV) even before marriage. Yet he got married as it gave him, and his family, social acceptability.

There are several thousand Chamundeswaris who have been 'faithful' to their spouses and followed 'abstinence' – touted by the Union government as the two most effective ways of stopping the spread of HIV/AIDS. What answer does the government have for these hapless women?

According to government estimates, women in apparent monogamous relationships account for an increasing number of new HIV infections. Over 92,000 HIV-positive women are giving birth to children each year, though not all of these babies are infected. Thus, the disease is spreading from small groups of high-risk people in a few states to the general population all over the country.

Over 10% of the world's 42 million HIV/AIDS-infected people are said to be in India and of the five million people infected in 2002, over 600,000 were reported to be in the country. Although the infection rate is less than 1% of the adult population, India has the largest number of HIV-infected people — 4.58 million — after Africa. A sizable number of those infected are also in their prime productive age.

The prevalence of HIV/AIDS in India is estimated from data collected by the World Bank-funded National AIDS Control Organisation's (NACO) 455 sentinel sites, primary clinics and government hospitals. Sample data are collected from both high- and low-risk populations. The data from the low-risk antenatal care sites indicate the infection's spread to the general population.

How does HIV/AIDS spread? Generally, from high-risk behavioural groups, such as commercial sex workers, to a 'bridge' population, such as their married clients, and from them to their spouses and to the children born to them.

The first few cases of HIV infection were detected in India in 1986 among sex workers in Chennai. By 1994, NACO had identified 1.75 million people infected with HIV, concentrated mainly in Maharashtra and Manipur. In four years, 3.5 million people had fallen victim to the infection, which continued to spread to more states. Today, NACO considers the infection to be concentrated in six states – Andhra Pradesh, Karnataka, Maharashtra, Manipur, Nagaland and Tamil Nadu - which account for over 80% of all reported HIV/AIDS cases in the country. By mid-2003, Tamil Nadu had nearly half of the reported cases of AIDS in the country, followed by Maharashtra with over a fifth.

In India, the primary cause of the spread of HIV/AIDS is estimated to be sexual contact (85%), followed by blood and blood products (2.7%), transmission from mother to child (2.7%), and needle-sharing among drug-users (2.4%).

Ignorance and stigma

According to NACO's 2001 National Baseline General Population Behavioural Surveillance Survey, a study conducted nationally to understand the prevalence of HIV/AIDS awareness among the general population, over 70% of the women in the rural areas had not heard of HIV and of those who had heard of it in Bihar, Gujarat and Uttar Pradesh, half of them did not know that HIV could spread through sexual contact. In rural Bihar, hardly 18% of the women had heard of HIV or knew that it spread through sexual contact.

Only two-thirds of the women in urban areas and half of the women in rural areas knew that the infection could be transmitted from mother to child. Hardly one-third of those surveyed had heard of sexually transmitted diseases (STDs) and among those who had, only one-fifth knew that it increased the risk of HIV infection. Following this survey, NACO set a goal of starting a voluntary, confidential, counselling centre in every district.

According to NACO, the stigma attached to HIV/AIDS is the greatest obstacle to spreading awareness about the disease. The discrimination against people with HIV/AIDS takes many forms – children are thrown out of schools, and adults from jobs; women are sent out of homes, denied healthcare, and some even stoned to death or buried alive. The HIV-infected are denied basic human rights. According to Meenakshi Datta Ghosh, NACO's project director, the stigma attached to the infection is primarily because the first cases identified in Chennai were among sex workers. That is why so much of the infection remains underground and

Patients who are HIV-positive, attended by relatives at the Government Hospital of Thoracic Medicine in Chennai. India has 4.58 million HIV-infected people.

it is difficult to get accurate numbers.

So, how does the government estimate the number of HIV-infected people? After the first cases of HIV were identified in 1986, India set up a high-level National AIDS Committee. The next five years were marked by a period of high denial - that HIV/AIDS is an imported disease and it cannot happen here. In 1992, recognising that HIV is a growing problem, the Union government set up NACO and began the first phase of the National AIDS Control Programme or NACP (1992-1999). In this phase, NACO promoted HIV/AIDS awareness and set up state-level programmes to fight its spread. Testing for HIV prevalence at sentinel sites (designated testing locations) began in 1994. But, realising that the spread was rapid, NACO began the second phase of the NACP (1999-2004) and raised the number of sentinel sites from 55 in 1994 to 455 by 2002.

This phase involved the empowerment of State AIDS Control Societies, and greater involvement of local outfits such as non-governmental organisations (NGOs) and youth organisations. Surveys at the sentinel sites were first concentrated among the high-risk groups such as those with STDs, sex workers and needle-sharing drug users. Later, pregnant women in antenatal care centres – a low-risk group – were also screened for HIV. The numbers infected with HIV, according to the survey data, rose from 1.75 million in 1994 to 4.58 million in 2003.

According to Dr. Suniti Solomon, director of the Chennai-based YRG Care Centre, who first detected HIV infection in India, the number of HIV-infected has multiplied alarmingly. The centre provides treatment and care to 5,000 HIV-infected people. From one patient a week in the late 1980s, she now gets six to eight patients a day. If this is worrisome, her perception of the spread of the infection is shocking. She said in a recent newspaper interview: 'For every one HIV-infected person reported, there are up to 20 that go unreported'. Dr. Suniti attributes the following reasons for the rising number of HIV/AIDS cases in India: low perceptions of risk; lack of counselling and testing services; the stigma and discrimination attached to the disease; the absence of trained healthcare professionals; limited access to treatment; and poor treatment management regimes.

CIA numbers disputed

But many scientists and NGOs disagree with the numbers projected. The recent anti-HIV campaign, which involved visits to India by celebrity donors such as Microsoft chief Bill Gates (who has pledged a $200 million grant to deal with the HIV problem in India) and Hollywood actor Richard Gere got bogged down in controversy mainly because the projections about the numbers had a trace of exaggeration. For instance, the US Central Intelligence Agency (CIA) made a projection last September that the number of HIV-infected people in India would reach 25 million by the end of the decade – a figure picked up by almost all international donors and agencies.

The United Nations' Population Division projects the number of adult HIV-infected in India at 12 million by 2015 and the prevalence rate to reach 1.9% by 2019. Although former Union Health Minister Shatrughan Sinha had agreed that the number of HIV-infected is rising and the six high-incidence states 'do have a generalised epidemic', he said the figures were 'grossly exaggerated'. He condemned the projections made by the international agencies, saying 'the figures put out by the government are from sentinel surveys and no one else is authorised to release figures or projections'. But, as Richard Gere rightly responded, 'figures are not the issue. The point is that there are a lot of people who are HIV-infected'.

While the HIV/AIDS issue is a complex one, its control needs a concerted effort from many angles and at different levels, there are some who feel that the disease is receiving much more attention than it deserves, especially when more common diseases do not receive such special treatment.

According to Ossie Fernandez of the Chennai-based Human Rights Foundation, huge amounts are coming into India to deal with HIV/AIDS from the World Bank, aid donors and philanthropic groups. Between 2000 and 2005, they have pledged over $620 million towards HIV/AIDS awareness, prevention and treatment projects for the four million HIV-infected (this itself, he argues, is an over-estimate). But some 58 million people in the country are infected with Hepatitis-B and Hepatitis-C and the funds available to deal with them are grossly inadequate. A mere $60 million is enough to vaccinate every child in the country against

Sexual contact is said to be the main cause of HIV/AIDS spread in India. Sex workers and truckers are among the high-risk groups.

Hepatitis-B, but this is not forthcoming. He says: 'No one is talking about it, or even about tuberculosis or malaria – the two main killer diseases'. Ossie Fernandez says that the 'projected numbers (for HIV/AIDS) are condom-industry driven, and pointed out that several NGOs here have been told by their international donors to add an HIV component to whatever work they do - primary education, livelihood or child labour issues'.

Several senior scientists such as Prof. Sarman Singh, Head of Laboratory Medicine at the All India Institute of Medical Sciences in New Delhi, and Dr. Manu Kothari, former Head of the Anatomy Department at the King Edward Memorial Hospital in Mumbai, question the validity of the CIA figures. Says Prof. Sarman Singh: 'The methodology adopted for statistical enumeration and evaluation of scientific details needs to be seriously investigated'. Some NGOs such as the Human Rights Foundation are also questioning the way data are collected at the sentinel sites. Dr. A.K. Arun Kumar, spokesperson for the voluntary organisation Azadi Bachao Andolan, charged the CIA with trying to create panic among the people with exaggerated statistics. He accused the CIA of trying to build a market for multinational pharmaceuticals.

But there are others like Indira Kapoor, former South Asia director of the International Planned Parenthood Federation, who argues that if donors wanted to give money to India, there was no need to protest. She asks: 'If Bill Gates' funding can help find an AIDS vaccine (for which trials are on in Pune), why should we oppose it?'

Dr. Madhu Bala Nath, South Asia director, International Planned Parenthood Federation, agrees. 'We should not be caught up in numbers,' she says. According to her, there are patterns in the data that get lost in the controversy over numbers. It is important to notice the sharp rise in HIV infection among injecting drug users, the youth, monogamous women and homosexual men. 'Rather than localising programmes dealing with HIV, they need to be integrated into the country's main health programme and there is an urgent need to concentrate efforts outside the six high-prevalence states as well,' she says.

Government's role

But what is the government's attitude to dealing with HIV/AIDS? Says Health and Family Welfare Minister Sushma Swaraj: 'I will prove all experts wrong. We are taking on the disease from all fronts'. According to her, using condoms alone is not the answer to tackling the disease; the two most important things are 'abstinence' (from unsafe sex) and 'being faithful' (to the spouse). On her decision to take off air a condom advertisement, she says: 'Ours is a moral society. While tackling AIDS, you (cannot) say you lead licentious lives because (you can make use) of condoms. I do not think that should be the message'.

But says an NGO worker who did not wish to be named: 'Who is to define morality? Sex is a private, individual decision. It is difficult to monitor it. The government can help by spreading awareness about the causes of the disease, making accessible healthcare and medicine, bringing HIV/AIDS into the public health agenda and developing an environment where people with HIV can live with dignity'.

Said Mumbai-based Dr. Ishwar Gilada (who detected the first few HIV cases in Mumbai in 1986), in a recent television interview: 'No one in the government is taking responsibility. Not one rupee is spent by it for HIV programmes'. All the money spent on HIV in India, according to him, comes as international loans and grants. This has, in fact, affected the efficacy of the HIV/AIDS programme in the country.

A recent report, 'Missing the Message – 20 years of learning from HIV/AIDS', by Panos, a London-based NGO, points out that the global trend of achieving quick, efficient and visible results has driven donors to fund shorter-term — usually three-year — projects. But in dealing with a problem like HIV/AIDS, where the infection has to be tackled from its roots, it is bound to take much longer to see some concrete results. Then comes

the issue of spending. Most funds, according to the report, get used up in creating elaborate organisational structures rather than in addressing the needs of those affected. This slows the impact of government programmes.

Agreeing that India has been slow in tackling HIV/AIDS, Meenakshi Datta Ghosh insists that things are changing now with the global public-private partnership called the Global Fund to Fight AIDS, Tuberculosis and Malaria announcing a $100-million grant to distribute antiretroviral (ARV) drugs free in India. The global '3/5 initiative' promises to bring free ARV treatment to three million people by 2005 (that is why the initiative is called 3/5).

Says P. Kausalya, president, Positive Network of Women in Tamil Nadu: 'Though ARV treatment costs have come down sharply — from Rs.30,000 a month in the early 1990s to Rs.1,200-1,500 a month today — still, it is beyond the reach of many. The 3/5 programme will benefit HIV-positive people greatly'. Until now, ARV drugs are not administered in government hospitals because of its high cost and patients receive treatment only for opportunistic infections. Says K.K. Abraham of the Indian Network of Positive Persons: 'There is a need to strengthen diagnostic facilities in all the districts, along with providing free ARV treatment'.

ARV therapy, given to people whose viral load has crossed a certain limit, is known to delay the progression from HIV infection to AIDS and thus prolong and improve the quality of the patient's life. In India, free ARV treatment (under the 3/5 global initiative) is to be concentrated in the six states where the incidence of HIV is high.

Address broader issues

According to Bimal Charles, Director of the Voluntary Health Services-AIDS Prevention and Control Project, free ARV treatment can significantly reduce mother-to-child transmission, one of the most disturbing ways HIV is spread. Says P. Kunanatham, the Chennai-based UNICEF (United Nations Children's Fund) consultant for the Prevention of Parent-to-Child Transmission: 'This can help reduce the spread of the infection. For instance, in Tamil Nadu, 1.1 million women get pregnant every year. Of these, 16,000 are infected and they pass on the infection to at least 5,000 babies every year'.

Although money is pouring into India to tackle HIV/AIDS, the country is nowhere close to beating AIDS, says a World Bank review on India's National AIDS Control Project that the Bank funds. According to the report, the 35 State AIDS Control Societies and 735 NGOs dealing with HIV/AIDS lack the basic resources to deal with the disease. About one-third of the jobs in State AIDS Control Societies remain unfilled. Many NGOs lack the technical skills to implement HIV/AIDS control programmes. And field data remain unsatisfactory because only 40% of the groups designated for collection go to the field regularly and send information to the NACO computer database. The review also faults NACO for its 'deficient' supervision of state projects and NGOs that work in the field.

NACO recognises that its project alone cannot beat AIDS. As Meenakshi Datta Ghosh says, 'NACO-run project touches only the fringe of the problem'. She feels that there is a need to co-opt the existing primary health centres to deal with HIV/AIDS in coordination with other disease control programmes, and to involve the business community.

The Bill and Melinda Gates Foundation, which has pledged $200 million in the next five years to fight HIV/AIDS in India, has many plans. According to Ashok Alexander, the New Delhi-based director of the Foundation's India Aids initiative, plans are afoot to establish 'good health' clinics for people with STDs. Many of the centres are to be located in the 9,000 petrol stations owned by the Gates Foundation partner, Indian Oil Corporation.

But, according to the Panos report, it is widely recognised that an important step in dealing with HIV/AIDS is to bring about behavioural changes. For that, people must realise that they are vulnerable to the infection and must have the urge to know more about it. This will take a long time to happen as for most people, education, employment, drinking water and nutrition assume priority over HIV/AIDS.

That social and economic vulnerabilities lie at the root of commercial sex, population movement (cross-border and rural-urban migration) and trafficking that fuel HIV/AIDS is an accepted fact. Thus, all HIV/AIDS intervention programmes need to be addressed in the broader framework of poverty, inequity, literacy and gender imbalances.

But, contrarily, most programmes are isolated and generally follow a top-down approach of information dissemination. There is no participation of communities in generating information geared to their needs; neither is there any programme involving all the stakeholders.

What is the way forward? AIDS is not an emergency, but a development crisis, emerging over a long period of time. It is important that the government neither panics nor remains complacent – it should take responsibility and act. Successful models, which address social and economic issues, to stop the spread of HIV/AIDS – such as those adopted in Uganda and Brazil – are instructive. Behavioural change, which will take long to happen, is fundamental to dealing with the problem.

Dr. Suniti Solomon strongly believes that women need to become the agents of change, though she realises that this is easier said than done. Dr. Suniti said at the recent Retroviruses Conference in Boston: 'The world is changing fast. But men continue to dominate women, through patronisation, violence or mental coercion. To question the way our society is built is a good beginning in dealing with HIV/AIDS'.

— *Frontline* (India), 2 January 2004.

The Indian dilemma: Through the eyes of a visitor

***RICHARD STERN* is an AIDS activist based in Latin America who attended the World Social Forum in India. He does not pretend to be an expert on the AIDS crisis in India after spending just 10 days in Mumbai, but feels compelled to at least place certain issues into a public forum with the hope of stimulating further discussion and debate.**

As a country overwhelmed by poverty as well as a myriad of other social problems, India's AIDS tragedy is hard to focus on, and the magnitude of the situation is only just becoming visible. The World Social Forum and the International Health Forum for the Defense of People's Health, held in Mumbai from 14-21 January, helped to place AIDS in the national spotlight, albeit briefly.

Among India's many other overwhelming problems, there are an estimated four million People Living with HIV/AIDS (PLWA). In a country that has over 1 billion people, the 'incidence' of AIDS is still relatively low, less than one half of one percent, but the numbers are still staggering. Care and treatment are virtually non-existent. According to Sanjay, a Person Living with HIV/AIDS, 'more than five years ago, the government promised to begin providing medications for opportunistic infections, but they still haven't done so. There is no Bactrim, no Fluconazole'.

Ironically, India is home to CIPLA, Ranbaxy, and Aurobindo, all of whom export generic anti-retroviral medications to other countries, but even at the price of less than $1 per day, these medications are unavailable to Indians who need treatment now, an estimated 300,000. An average salary for a working-class Indian in Mumbai is $30-40/month and most people with AIDS are unemployed, and have to rely on charity just for food.

Government promises scale-up

The government has recently announced that it will begin providing treatment for 50,000 people beginning in April of 2004, but activists I spoke to were skeptical of the government's commitment to follow through. According to Vivek, 'they have not allocated any budget for the purchase of these medications, so how are they going to buy them? We have not heard of any concrete plan to implement this promise'.

The NGO Communication for Health India Network (CHIN) raised similar questions in their Newsletter distributed at the World Social Forum. CHIN voiced several concerns including 'What are the plans for making available low-cost second line drugs?', and 'Would health personnel be trained adequately enough to handle problems related to drug distribution such as laboratory, and the delivery system itself and handling side effects?' They also referred to issues related to ARV availability for women and children, gender issues, confidentiality, and criteria for selection of clients to receive free drugs.

The biggest concern that this writer has, after witnessing innumerable announcements by governments about scaling up plans that were never followed through on, is 'will this really happen in India or is it a placating strategy, designed to silence activists and create a false impression that something meaningful will occur?'

The NGO Coalition SAATHII (Solidarity and Action Against HIV Infection in India) presents a rather pessimistic overview of the AIDS panorama in India. According to the SAATHI website:

- Care to PLWA is refused even in governmental hospitals on such grounds as lack of 'adequate infrastructure' and lack of 'expertise' in treating PLWA.
- Private hospitals almost always deny treatment to PLWA.
- Confidentiality of the patient's HIV status is not maintained in government and private hospitals.
- Drugs for opportunistic infections are not always available in government hospitals.
- Surgical treatment is not provided to PLWA even if there is an absolute necessity for surgery.
- Even in centres which are treating PLWA, the basic facilities are inadequate.
- Emergency/critical care for PLWA is non-existent.

In a widely publicised speech delivered at the Indian National AIDS Conference in Chennai late last year, activist Dr. Subha Raghavan demanded that the Indian government respond to the crisis in care and treatment. 'Treatment is a basic human right...in the past 3-4 years I have lost seven of those young men who went to school with me. How can they not be my family, they work and serve my village and take care of my family'. She added that 'we are the manufacturer of cheap drugs for the whole world...it is unacceptable that the very same drugs we export to the whole world are not available at affordable prices in India'.

Raghavan finished by demanding that treatment access be made available by July of 2004 in India, and asked for support from UNAIDS and the WHO '3 x 5' team in implementing a plan: 'We demand that...WHO, UN agencies, bilateral partners, and foundations

work together in equal partnership with civil society and People Living with HIV in developing a comprehensive plan for immediate scale-up of ARV treatment in India'.

Perhaps as many as a thousand people in India do receive anti-retroviral medications that are provided by NGOs, including the Freedom Foundation in Bangalore, and the Naz Foundation in New Delhi.

Streets of Mumbai

As an outsider who came to find out about AIDS in India, it was impossible for me to ignore other problems that are much more visible. During my daily 75-minute taxi ride from my hotel to the site of the World Social Forum in Mumbai, it was absolutely overwhelming to see the number of homeless families who simply camp out by the side of the Western Express highway and on the sidewalks of the major thoroughfares that wind their way through Mumbai. Returning along the same route at night, it is as if the homeless turn to corpses as they lie fully wrapped in blankets along the sidewalks and roadsides. And aside from those who are homeless are thousands of others who seem to have put together several pieces of tin and some wood and plastic to create a makeshift shelter. Peering into some of these shelters at traffic lights, I could see five or six children and their mother, cooking something in a pot over an open fire fuelled by sticks gathered from nearby bushes.

At the World Social Forum, and the International People's Health Forum which preceded it, AIDS was a topic of concern in many presentations. The Indian Lawyer's Collective of Mumbai sponsored programmes focusing on intellectual property issues which threaten the future ability of companies such as CIPLA to continue to export their medications on the world market. According to Anand Grover of the Lawyer's Collective, India must enact TRIPS-compliant patent legislation by the end of 2004, and this may mean that CIPLA will have to respect local patents that have been filed on ARV medications, meaning that they cannot export their products. Up until now, Indian law has not recognised any patents on medications, only on 'processes' for producing the medications. Thus, any company that could develop a new process for producing a medication could do so. But the World Trade Organisation is requiring India to enact a law that will fulfill the requirements of the TRIPS Agreement.

Even as the World Social Forum was concluding, local English newspapers carried a story about an apparently precedent-setting case won by Anand Grover in the High Courts of India, in which a woman who had been fired from her job in an insurance company for being HIV+ was ordered to be reinstated within one month. But discrimination even among medical personnel is described as being rampant. Indira from Chennai in South India described how an AIDS support programme in that city fired all of its HIV+ employees. Many PLWA stated that most physicians will refuse to treat a person if they know the person is HIV+.

WHO '3 x 5' actions unclear for India

The World Health Organisation sent several members of its '3 x 5' Core Team (three million people on treatment in developing countries by the year 2005) to Mumbai for the two conferences, but it was clear that the 3 x 5 plan does not address India's country-specific realities, and that at the moment it is a 'theoretical prescription' for India. Craig McClure and Ian Grubb from the WHO Geneva Core Team gave presentations at a Plenary Session attended by 800 people at the International Health Forum for the Defense of People's Health on 14 January. However, there was no participation in this event from India-based staff of the UN agencies who are focused on scaling up ARV access. So the local situation remained very unclear, and there is no evidence that any of Subha Raghavan's demands listed above have been addressed in India.

In other developing countries during the history of the AIDS epidemic, WHO/UNAIDS staff have, with notable exceptions, clearly failed to take a pro-active role in supporting goverments in implementing treatment, and have tended to identify more with elite government decision makers rather than pushing these leaders to help poor people. Given the fact that India has by far the lowest-priced ARVs in the world, it is indeed shocking that, seven years after ARV access became virtually universal in Europe and the United States, the government of India still does not provide treatment.

Delays in Global Fund implementation

However, perhaps the biggest tragedy in India is the failure to even begin to make use of extensive resources that have already been allocated by the Global Fund for AIDS, Tuberculosis and Malaria for India.

The Global Fund contract for the proposal relating to HIV/AIDS, approved in Round Two (January of 2003), still has yet to be signed. Although the proposal itself is for

about $200 million, including all components, it only provides treatment access for about 19,000 people over the five-year period (roughly $7 million based on current costs of ARV access in India). According to current estimates, as many as 300,000 people in India need treatment access now, and over a million will be in need in five years. As such, the proposal does not reflect the Global Fund policy of funding proposals that will significantly scale up treatment availability for PLWA. Most Indians with AIDS will not benefit from the proposal.

Other elements of the AIDS infrastructure that would be funded by the proposal such as voluntary testing and counselling cannot be put into place until the proposal is signed and funds are disbursed, further delaying any treatment access scaling-up that would come as a result of the proposal. A representative from PNUD in India who attended the session sponsored by the Lawyer's Collective told me that there is virtually no infrastructure related to scaling up ARV access in India, and that the infrastructure would need to be in place for treatment access to begin. He defended the fact that only about 5% of the Global Fund proposal will actually go towards the purchase of antiretrovirals, claiming that the government is simply incapable of providing treatment to a large number of people. When I reminded him about Paul Farmer's work in rural Haiti and its success, he insisted that Haiti has a more developed health care infrastructure than India.

Other activists present in the Forum were angry about the lack of emphasis on ARV access in the Global Fund proposal, and claimed that they were never consulted about possible input into the proposals presented by the Country Coordinating Mechanism (CCM) to the Global Fund.

The Global Fund CCM seems to be very much dominated by the government, in the sense that few HIV+ Indians I spoke to were even aware of its existence, or the resources it potentially may have provided or could at least begin to provide. The fourth round of proposals for the Global Fund will close in April, and there is a movement among activists in India to submit a proposal focusing on ARV access. But one has to wonder what the Fund's reaction will be, given that India has been unable to even begin to make use of the nearly $200 million that has already been approved.

Activists from TAC in South Africa, HealthGAP in the United States, as well as from Brazilian NGOs, were present at activities during the World Social Forum, and discussed implementation of collaborative actions that would provide support from the international community to indians living with HIV.

Men who have sex with men

Compounding India's AIDS problem is that fact that homosexuality, even among consenting adults, remains illegal, meaning that most gays, lesbians and transgendered people remain hidden, which compounds prevention efforts.

Paradoxically, the streets of Mumbai remind one, at least superficially, of San Francisco's Castro street gay district, in the sense that it is culturally acceptable for men to walk down the street hand in hand. In a half-hour walk through the crowded Colaba district, I counted at least 30 male couples, generally in their teens and 20s, walking hand in hand, but in Indian culture this is completely acceptable behaviour for heterosexuals.

More overt homosexuality is not visible in bars or other socially tolerated venues, but is dramatically visible at the urinals in the huge restrooms in Mumbai's commuter railroad stations. There seems to be a section reserved for 'cruising' among gay men, and there were dozens of men presumably 'seeking sex with men' present at the Churchgate station men's room during rush hour one evening.

Equally visible were many men who were obviously cruising a darkened section along the beach just to the south of the famous Taj Mahal Hotel in Colaba. So if Indian authorities, who tend not to visit such places, try to deny the existence of a substantial community of men who have sex with men, they are sorely mistaken.

According to Fridae an Asian gay and lesbian network, there is a whole gay culture associated with the railroad system. 'Tuesday is for Dadar railway station...Wednesday is for Bandra station, platform one booking counter...the crowd here tends to be what the snobbish upper crust of Mumbai would refer to as the lower classes...on the express trains, the second-to-last compartment is often the cruising section of the train'.

Mumbai, a city of 14 million, has only one gay bar, which is only open one night a week, but there is an underground network of contacts and parties and there are several gay associations as well. But the law against 'unnatural acts', enacted by the British in 1871, carries stiff penalties, and, even if rarely enforced, casts a deep shadow over India's gay community which is highly repressed by culture as well as law.

According to Indian gay activist Ashok Row Kavi, Director of the Humsafer Foundation in Bombay, 'Indian gays are a product of Indian civilisation. We will be reflecting all the contradictions of Indian society.... Gay men in huge numbers are infected. I estimate over 60% HIV prevalence in the 520,000 Men-having-sex-with-men sector in Bombay. But they are dying futile, unsung deaths'.

According to Row, the Indian term for gay sex is *musti*, or mischief, and young Indian boys who engage in gay sex are often joked about....*Musti* is considered something that takes place along with marriage but never in place of it. *Musti*, then is something to be joked about, it is never serious, and the deeper romantic feelings that Western gay men often have about their relationships are alien to Indian culture'.

Rainbow Planet, a coalition of NGOs that supports sex workers as well as sexual minorities in India, held a well-attended plenary session at the World Social Forum in which various sex workers, as well as transgendered, lesbian and gay people, gave testimonies as to the abuses and discrimination they are constantly subjected to.

People power challenges profits, politics

Max Martin, Mariette Correa and Unnikrishnan PV

When leaders of nation states, pharma giants, donors, grassroots movements and people living with HIV/AIDS come face to face in Bangkok for the International AIDS Conference (11-16 July 2004), it will be a test of strength between profits, politics and people.

HIV/AIDS targets the poor, and spreads like wildfire under conditions of poverty, conflict, displacement and weak public health and social safety systems.

Even as a thriving Asian business hub hosts the conference, it is imperative to study the extent of the HIV/AIDS crisis in the continent, the reasons behind such a rapid spread and the grim background in which this tragic drama is unfolding. Such an understanding is necessary to chart out combat strategies against it.

This article discusses the current international scenario, the spread of HIV/AIDS in various regions of Asia, and factors such as money, political will and people's action needed to combat the spread of the epidemic.

Global sweep

HIV/AIDS is one of the greatest humanitarian crises of all time. At the end of 2003, an estimated 40 million people around the world were living with HIV/AIDS, including the 5 million people who acquired HIV that year, UNAIDS has noted. And the epidemic claimed an estimated 3 million lives in 2003.

An additional 45 million people in 126 low- and middle-income countries will be infected between 2002 and 2010, UNAIDS warns.

Sub-Saharan Africa is the worst-affected region in the world, with 26.6 million people currently living with HIV/AIDS, including approximately 3.2 million people newly infected in 2003. In seven African countries, 20 per cent or more adults (defined as people aged 15-49 years) are estimated to be infected. In these countries, AIDS will claim the lives of around a third of today's 15-year-olds unless actions are taken to slow the epidemic.

Since it began its onslaught in sub-Saharan Africa, this pandemic has set up its new grim theatre in Asia, casting a shadow of death over millions of people in some of the world's most populous nations. It is threatening to wipe out economic and development gains and social stability attained over years.

Such a fate can be prevented only if the world succeeds in mounting a drastically expanded prevention effort.

Asian drama

UNAIDS estimates that over 1 million people in Asia and the Pacific acquired HIV in 2003, bringing to an estimated 7.4 million the number of people living with HIV in the region, going by UNAIDS figures. Some 500,000 people are estimated to have died of AIDS in the past year.

'The question is no longer whether Asia will have a major epidemic, but rather how massive it will be,' said Dr Peter Piot, Executive Director of UNAIDS, in an interview in *Time to Act: HIV/AIDS in Asia*, an ActionAid publication.

With the exception of Cambodia, Myanmar (Burma) and Thailand, national HIV prevalence levels remain comparatively low in most countries of Asia. But there are localised 'simultaneous' epidemics affecting millions of people. A small increase in prevalence percentage in a country like India or China will be translated to hundreds of thousands of people.

HIV/AIDS targets the poor, and spreads like wildfire under conditions of poverty, conflict, displacement and weak public health and social safety systems – a common condition in many Asian countries.

The thriving sex racket and human trafficking — often flourishing under a thin veneer of business and tourism promotion — in the region fuel the epidemic.

In an atmosphere of newfound respect for market reforms, drug companies and private hospital and health care groups are allowed to place profits above people. When governments dance to the tune of international financial institutions, poor people — who are the most vulnerable to any disease — find medicine and health care unaffordable.

Alarm bells in South Asia

South Asia is home to about half the world's poor people living on less than $1 a day.

Infectious diseases like malaria, tuberculosis (TB) and respiratory illnesses have been a major cause of death and disability. The resurgence of TB and the AIDS-TB nexus pose a major threat.

By end-2003, there were up to 8.2 million people living with HIV/AIDS in South and South-East Asia, a UNAIDS report notes. (In fact South-East Asia accounts only for 600,000 of them, less than one-tenth.)

The HIV/AIDS picture in South Asia remains dominated by the epidemic in India, where between 3.82 and 4.58 million people were infected nationally by the end of 2002. In 2003, at least 300,000 people acquired HIV as earlier reports suggest. China's official estimates put the number of people living with HIV at 840,000 as of mid-2003. In these two countries, even a small rise in the relatively low overall prevalence rates will translate into huge numbers.

The epidemic, fuelled by poverty, illiteracy, gender inequality and social marginalisation, is further stoked by drug abuse, conflicts, disasters and displacement. A crucial issue is the lack of access to health care, made worse by budget cuts.

Blunt remedies of East Asia

East Asia, a tapestry of dramatically different cultures, lifestyles and income levels, appears to be a low-prevalence region. In East Asia and Pacific there were 1.3 million people living with HIV/AIDS by the end of 2003. But it is just the beginning.

HIV/AIDS is a snowballing crisis in China — a ten-fold rise is feared in five to ten years. Still policy-makers tend to consider HIV as an 'alien' threat and impose discriminatory, if not draconian rules, exclusively screening high-risk groups, migrants and prison inmates in many countries. Tests without consent, breaking confidentiality, and denial of treatment by the medical community are some of the rights issues.

Human trafficking and sex rackets flourish in the region, fuelled by affluence as well as poverty — providing an added risk.

Public health systems are strong in the region. People living with HIV/AIDS can get free or subsidised drugs in Taiwan, Japan, and Hong Kong. But migrants often do not get these facilities.

Combating AIDS terror in South-East Asia

Countries with stark contrasts in social and economic terms struggle to cope. In

Myanmar (Burma), East Timor, and Laos poverty is a problem and in many 'Asian Tiger' economies, health and education systems have yet to recover from the 1997 economic crisis. A prevalent myth of low infection may weaken the fight against HIV here.

A November report of UNAIDS notes that South-East Asia is one of the regions where infection is increasing rapidly. As of end-2003, 600,000 people were estimated to be living with HIV/AIDS in this region. An estimated 55,000 people became infected in 2003, and about 45,000 people died, UNAIDS notes.

Sharp economic disparities lead to large-scale cross-border migration in the region. Thailand, for instance, has 2.5 million migrant workers, only about 500,000 of them documented. For them, access to health care is limited. Trafficking of

People first

People's Health Movement to unveil a People's Charter on HIV/AIDS at Bangkok

The People's Health Movement (PHM), a network of health workers and campus, peace, consumer and social activists from across 100 countries will unveil a People's Charter on HIV/ AIDS at the Bangkok International AIDS Conference.

The charter notes that keeping HIV/AIDS drugs unaffordable for poor people is a violation of international law, and legal action is needed worldwide to scrap patent regimes that hike up their prices.

The majority of impoverished AIDS patients are denied access to treatment against the principles of the United Nation's International Covenant on Economic, Social and Cultural Rights (ICESCR), the PHM argues.

Armed conflicts and aggressive market reforms drain funds from weak public health systems, making poor people in Asia more vulnerable to HIV/AIDS and other epidemics. 'Putting profits over people would be tragic,' said Dr Zafrullah Choudhury from Bangladesh.

The charter calls for action, including public interest litigation against drug patent laws that will soon be binding on developing countries as stipulated by the international trade regime.

The charter promotes a people's perspective on HIV/AIDS and related issues including access, rights and trade. Deriving strength from the People's Health Charter, the largest consensus document on health and the guiding spirit of the People's Health Movement, it calls for better public health care systems and UN initiatives.

PHM workers believe the HIV/AIDS charter has global relevance. 'The lives that have been lost in Africa should not go to waste,' warned Patricia Nickson, a public health specialist from the Democratic Republic of Congo.

Central Asia's visible HIV/AIDS scenario is just the tip of the iceberg. Drug trafficking routes cut through here, drug abuse has emerged as a key factor that is amplifying the epidemic.

women and sex trade are flourishing here. This region, one of the world's leading recipients of foreign direct investment, still finds it difficult to provide care and support and antiretroviral (ARV) therapy to many of its citizens. Cambodia is the worst affected, with an estimated 157,500 people living with HIV/AIDS by early 2003. Myanmar (Burma) also faces one of the worst crises.

Silent spread in Central Asia

Central Asia's visible HIV/AIDS scenario is just the tip of the iceberg. Drug trafficking routes cut through here, drug abuse has emerged as a key factor that is amplifying the epidemic. Unsafe sex is another fuel. The health care systems are still recovering slowly — amid budget cuts — from the collapse after the demise of the Soviet Union. Surveillance is very poor. In war-torn Afghanistan, surveillance is virtually non-existent.

According to UNAIDS, Central Asia and Eastern Europe continue to experience the fastest-growing epidemics in the world, with an estimated 230,000 new infections and 30,000 deaths in 2003. An estimated 1.5 million people live with HIV/AIDS in this region. Though the worst-hit countries are the Russian Federation, Ukraine, and the Baltic states (Estonia, Latvia and Lithuania), HIV continues to spread in Kazakhstan, while more recent epidemics are now evident in Kyrgyzstan and Uzbekistan.

Central Asia is a region of 'youth' — people under 18 represent about 43 per cent of the total population. Poor treatment practices and lack of pharmaceuticals are worsening the situation. Iran has a vibrant public health system, but it is also vulnerable to funding cuts.

Money matters

There was a substantial cut in public health expenditure during the 1990s in many Asian countries, the same years that saw the rapid rise of AIDS in the continent. For example, in India the government spending on public health fell from 1.3 per cent of the GDP to 0.9 per cent during the 1990s. The cut came amid the backdrop of phenomenally wasteful military expenditure.

The Global Fund, a $10 billion resource, is a new initiative to fight HIV/AIDS, tuberculosis and malaria. These three diseases kill more than 6 million people each year, and the numbers are growing. But till today, the fund has pledged only a little more than $2 billion over three rounds of approval. The negative points in this setup are the unpredictability of funds, lack of voting rights for the board member representing communities living with the diseases, and huge administrative expenses.

At the Global Fund board meeting that took place in March 2004, the board approved a $52.7 million budget for 2004. But over half of it — $30.5 million to be exact — was earmarked for secretariat expenses and $22.2 million is for Local Fund Agent fees. Such priorities made the 66 per cent increase in the fund — from the $31.8 million in 2003 — meaningless. 'This transmission loss is astronomical and criminal,' said an analyst.

WHO created the 3x5 initiative to meet the urgent need of antiretroviral treatment (ART) for 6 million people living with HIV/AIDS in developing countries. So far only 400,000 people have access to ART. WHO and its partners are committed to providing ART access to 3 million people living with HIV/AIDS in developing countries by the end of 2005 – hence the name 'three by five'.

WHO estimates that even with the cheapest drug prices, the cost of implementing 3x5 will reach $4.9 to 5.5 billion by the end of 2005. WHO itself will need an extra $350 million for this. Global Fund officials estimate that only 240,000 people or eight per cent of the total number of patients will be on ARV treatment by 2005. With increasing living costs and cuts in social security, such funds will play a crucial role in deciding the fate of millions of people living with HIV/AIDS.

Shylockian drug giants

In the context of shoestring budgets to fight HIV /AIDS, drug

companies are squeezing out the bulk of the resources available. In fact HIV/AIDS has left bloodstains on the balance sheets of many pharma giants, who found the latest and fastest money-spinner in its treatment. Exorbitant prices have resulted in many deaths of poor people. The proposed changes in patent laws by the end of 2004 will make antiretroviral drugs even more unaffordable.

A ray of hope came when some of the pharmaceutical companies in the developing world started offering low-cost ARV drugs for South Africa. However, the generosity of these drug multinationals is not being extended to many other needy countries.

Some countries whose leaders are attending the AIDS summit — such as India, Brazil and Thailand — are capable of producing more antiretroviral drugs than they need. 'They can supply free or low-cost drugs to countries that need them,' said Thaksin Shinawatra, Prime Minister of Thailand, in a recent media interview. For instance, Thailand could produce enough antiretroviral drugs for 200,000 people, while only 70,000 Thais need them.

It is time the drug industry learned lessons from the music industry, which charged exorbitant prices only to find pirated copies of their products the world over. However, ARV medicines are not a hobby, but a matter of survival. The battle against HIV/AIDS is a fight for better politics. It is essentially a fight to tilt the balance and place people above profits.

Call for action

(a) Synergy

Since HIV/AIDS has emerged as a crisis that cuts across geographical, class and sector barriers, it is time that people adopt a multidisciplinary and multisectoral approach to fight it.

One of the impediments to synergy is the differences in philosophy and practices of

AIDS activists and health activists. AIDS activists argue that when people are dying they cannot wait. On the other hand, health activists argue that a sustainable response can come only from a strong public health system. But they both share common ground in putting people first. So it is important to develop future strategies on this common ground.

Another important constituency that needs to join in the fight against AIDS is the peace activists.

Firstly, conflicts and wars fuel HIV by exacerbating poverty, forced migration, prostitution, malnutrition and ill health, as reports from Central Asia, the new HIV hotspot, demonstrate.

Secondly, the arms race diverts funds meant for public health and social safety. Global military spending, on the rise for five straight years, increased by 11 per cent in 2003 to total $956 billion, according to the Stockholm International Peace Research Institute.

Thirdly, there is growing concern about those involved in conflicts, including occupation forces, abusing and assaulting local women and children, spreading the infection. 'Historically US military bases have been breeding grounds for social diseases and sexually transmitted diseases,' said Satur C Ocampo, president of Bayan Muna (People First), a political party in the Philippines, in an interview in *Time to Act*.

(b) Communication

UN Under Secretary-General Shashi Tharoor recently said that children orphaned by people with AIDS make one of the 10 humanitarian stories largely underreported by the media. By the end of 2001 there were an estimated 14 million surviving children under the age of 15 who had lost one or both parents to AIDS. In sub-Saharan Africa and Asia, the growth in the number of orphans is primarily driven by the AIDS epidemic. Innovative ways of using airtime and megabytes will define the future of the campaign against HIV/AIDS. The battle against AIDS should spread to newsprint, the airwaves and cyberspace.

(c) Politics

As HIV/AIDS is ultimately a development issue, it is time politicians and policymakers reorient their approach to combating the menace. Mainstreaming, anti-HIV/AIDS policies into broad social sectors such as health, education and women's empowerment can be the first step forward. Political parties must also recognise the long-term impact of the disease and contribute to the fight against the disease. Recent elections in several Asian countries were a missed opportunity for political parties in this regard.

(d) People's action

HIV/AIDS is no longer a boardroom issue for armchair activists and good-hearted donors. Learning lessons from the direct action against wars in our time and the fight against tobacco, it is time for all concerned people to get on to action spots, including the courts and streets. The People's Charter on HIV/AIDS calls for public interest litigation (see box). Action any day and anywhere is better than aid and slogans. The direct involvement of people from all walks of life can tilt the balance in favour of those suffering from HIV/AIDS especially in their legal battle to secure their rights.

It is literally a matter of life and death.

Paper presented at XV International AIDS conference, Bangkok (July 11-16)

Max Martin is a freelance journalist based in Bangalore (India) specialising in health, development and forced migration issues.

Mariette Correa is a health analyst based in Goa (India) specialising in HIV/AIDS.

Unnikrishnan PV is a medical doctor working on health and humanitarian issues with the People's Health Movement and ActionAid International.

The HIV/AIDS epidemic is at a critical stage

Burma Issues

There is no denying that HIV/AIDS has become a serious problem in Burma. The following articles from *Burma Issues* magazine give a background to the social and economic factors that have contributed to the spread of the disease and its growth in neighbouring countries. Economic problems, meagre resources, poor health facilities, poverty, cheap heroin and internal conflicts are part and parcel of the problem.

The Irrawaddy

As Burma's AIDS casualties mount, the local media continues to show only the official picture.

Burma is undergoing an epidemic of the Human Immunodeficiency Virus (HIV) and AIDS, according to the country's own National AIDS Programme (NAP), the World Health Organisation (WHO) and the United Nations Development Programme (UNDP). In 1996, it was estimated that approximately 500,000 people in Burma had been infected by HIV. Of an estimated 160,000 drug addicts, mostly heroin users, at least half are said to be infected with HIV. Estimates of HIV infections in Burma are extremely crude due to insufficient testing and monitoring procedures, education, prevention and care programmes in Burma.

The WHO Global Programme on AIDS estimates that HIV is currently spreading faster in Asia than in any other part of the world. WHO has identified the four hardest-hit countries in the Asian region as (in order of HIV prevalence): India, with more than 1.5 million people infected out of a population of over 1 billion; Thailand, with at least 800,000 of its population of around 60 million; Burma, with around 500,000 of 45 million people, and Cambodia, with close to 200,000 of 7 million people.

The first HIV screening programmes in Burma were initiated in 1985 by the military government of General Ne Win, which preceded the present regime.

In 1988, Burma formally identified one case of HIV infection, when a 37-year-old patient at Rangoon General Hospital tested positive for HIV. In 1989-90, significant rates were identified in intravenous drug users (IDUs). Since then, the virus has been found wherever testing could be done, and in spite of the limited data, it is accepted that HIV has spread at an alarming rate. Factors contributing to the spread of HIV/AIDS include the country's ongoing political crisis, mass population movements, poverty, backward medical conditions, and the flood of cheap heroin. The four principal transmission routes of HIV spread - unprotected sexual intercourse, sharing of injection equipment among drug users, transfusion of infected blood and blood products, and mother to infant - have been in evidence in Burma.

It is estimated that Burma now produces more than 50% of the world's raw heroin. While most of the drug is sold abroad, Burma has a little-acknowledged but widespread domestic heroin market. An estimated 60-70% of all IDUs in Burma have HIV. The very high rates of HIV infection among IDUs are primarily due to needle-sharing,

which is the principal risk behaviour for HIV infection among addicts worldwide. Possession of drugs and syringes is illegal in Burma. Syringes are in short supply, and addicts go to tea stalls, shooting galleries behind shops and tea houses, where professional injectors give them their doses. Up to 40 people may be injected with the same needle. Most of these addicts are young, and the spread of HIV infection to other groups, including wives and girlfriends, is likely.

The HIV epidemic among IDUs in Burma has spread to drug users in at least two of Burma's border nations, China and India. The Burma-China border zone is currently the highest prevalence zone for HIV infection in China, and drug users on the Indian side, in the border state of Manipur, have among the highest rates of infection in India (see accompanying story).

Condoms were illegal in Burma until 1992, and they are now used by less than 1% of the population, making almost all sex unprotected. The condoms which are available are generally of questionable quality, and even when they are available, they are too expensive for the average Burmese. The UNAIDS programme found in 1996 that 2% of pregnant women tested in Burma carried HIV, a higher rate of prevalence among pregnant women than any other country in Southeast Asia, including Cambodia and Thailand.

Prostitution is illegal in Burma, and men who patronise sex workers can be charged under laws dating from the 1880s British colonial penal code, which equated these acts with rape. People charged under this code face up to ten years in prison. As a result, prostitution has been driven underground, keeping most sex workers out of the reach of public health workers who might educate and promote prevention of HIV to sex workers and clients.

Trafficking of Burmese women into other sex markets in the region is also a significant problem as most of the sex workers are in lower-class brothels and are often

HIV/AIDS message in Burma. The severity of the epidemic can no longer be ignored as it threatens the country's social fabric.

ignorant of, and cannot gain access to education about, HIV/AIDS. There are a significant number of brothels in border towns, which together with the high rate of tattooing and ear-piercing among most of the ethnic groups of Burma (which are rarely performed with sterile equipment) have immense potential for spreading AIDS throughout cities, towns, and the most remote villages. A large proportion of sex workers in northern Thailand come from Burma's Shan state and Yunnan, and they carry the virus with them when they return to Burma.

The current situation is of major concern in Burma's ethnic minority regions, where the regime is trying to return insurgent groups to the legal fold through ceasefire agreements, and/or has a strong military presence. There are countless reports of rapes perpetrated against women (including those returning from working in the sex industry in neighbouring countries), putting these women at risk of infection. One study of HIV infection risks among men in the Burmese military found that risk behaviours were common, and included sex with other men, extra-marital sex with sex workers and inconsistent or absent condom use. This risk behaviour, compounded with blood transfusions on the battlefields and the other means of transmission, guarantees that HIV infection is continuing to spread rapidly throughout even remote areas of Burma.

Burma formalised HIV surveillance in 1992 when the Burmese government's National AIDS Programme initiated a structured HIV sentinel surveillance effort which twice a year conducts protocol surveys in selected sites on selected sub-populations. The NAP's efforts have shown that HIV prevalence rates have been steadily increasing and HIV is having a significant impact on the general population of Burma. This is evident from the rates of HIV prevalence found among pregnant women and blood donors. The most prevalent forms of transmission have been through IDUs and heterosexual sex. In Burma, HIV/AIDS risk will affect everyone: this is an epidemic which threatens to continue exponentially to destroy Burma's social fabric unless a concerted effort is made to address the main factors contributing to the rapid spread of HIV infection in the country.

Burma Issues is published by the Peaceway Foundation. Founded in 1990, it is devoted to a peaceful resolution to Burma's struggle for human rights and democratic rule.

Spreading across Burma's borders

There is evidence to suggest that Burma is a main conduit of the AIDS route which carries infection from Thailand to the border and remote tribal areas of India and China. Many governments consider cross-border migrant populations, which include workers, asylum seekers, refugees, underground groups, and ethnic minority groups, as the main transmission route for the disease across borders, due to poor living standards and drug abuse. While information about migration and HIV patterns is either nonexistent or inadequate, the increasing rate of HIV incidence in border areas, ports and markets is of concern.

It is possible that AIDS reached Burma via the border towns of Thailand, through the flesh trade and heroin use. It has spread through northern Burma to China's southern border region Yunnan and the isolated northeastern border state of India, Manipur, which boast the highest HIV/AIDS rate in these countries. The twin border towns of Tachilek in Burma's eastern Shan state and Mae Sai in Chiang Rai, Thailand, have in the past few years experienced a sharp rise in HIV among commercial sex workers and intravenous drug users. According to Burma's Health Ministry, HIV prevalence among pregnant women in Tachilek is the highest in Burma. It is already too late to identify the area or the group of people to blame for the AIDS route into Burma; the epidemic is by now spreading at an alarming rate both across and within borders and is having a disastrous social and economic effect in the entire region.

The expanding heroin trade in Southeast Asia's Golden Triangle, the world's largest source of illicitly grown opium, has contributed to the epidemic of HIV/AIDS. Burma's military junta has been accused of quietly supporting the drug trade instead of concentrating on battling the heroin epidemic, and the ramifications extend beyond Burma's borders. Since the junta took over Burma in 1988, levels of drug addiction in China have increased more than seven times. Ruili, in western Yunnan just over the border from Burma, has emerged as the focus of public concern over AIDS in China since its first group of infections were discovered among local intravenous drug users (IDUs) in 1989. The National Institute on Drug Dependence, based in Beijing, reports that in 1989 there were about 70,000 addicts in China, and that by 1995 the number had grown to more than 500,000. Because IDUs repeatedly reuse non-sterile equipment, they have a high risk of HIV/AIDS infection. Over 70% of China's HIV-infected population is located in the border town of Ruili.

Mizoram, Manipur and Nagaland, India's three northeastern states bordering Burma, are among the poorest in India. Because the area is sometimes racked by insurgency, it has been closed to foreigners for security reasons, but has long been open to the heroin trade. Authorities estimate that $1 billion in drugs is transported to India every year, passing through Manipur. The state of Manipur had around 600 addicts in 1988 when the military junta took power in Burma, and by 1996 specialists in the region estimated that there were 40,000 addicts. The reported rate of infection among IDUs jumped from zero in 1988 to nearly 70% in 1992, according to the US Census Bureau. Manipur has the worst HIV/AIDS prevalence detected in India.

Border trade has made these border towns boomtowns, drawing sex workers, truck drivers and easy cash, the same combination of factors which spelled AIDS disaster in Africa. Sexual contact has been identified as one of the main transmission modes in cases of HIV infection found in Burma, Thailand and China. Contributing to the problem is the large-scale trafficking of women and young girls from Burma who are brought to border towns where they are sold into prostitution. These women and girls are in demand because customers perceive them as AIDS-free, coming from a relatively closed country. In reality these women and girls do not remain AIDS-free for long, as a number of their customers are already HIV-infected, whether through drug use or sexual contact. This, combined with the number of infected drug addicts, forewarns the future of these towns as ghost towns.

Socioeconomic factors inside Burma contribute to the speed of HIV infection. The effects of civil war and increasing poverty have led to a continuing outflow of Burmese people to the neighboring countries. Another huge problem is the lack of education about and prevention of infection. In 1994, a US public health expert reported that Burma did not allow regional programmes to warn people in Kachin and Shan states about AIDS. Community-based organisations are not allowed to exist, and ethnic language materials are effectively banned. The military junta has been accused of letting the virus go unchecked among segments of the population it considers security risks, such as students and rebellious ethnic groups.

There have been massive forced displacement programmes in border zones such as the tribal Shan state and the Rohingyas in Arakan

near the Bangladeshi border. These programmes and the tactics used in their implementation have led to accusations that the regime uses AIDS the way early North American settlers presented smallpox-contaminated gift blankets to Indian tribes, to wipe out an indigenous population through disease. The junta has been criticised for its relatively small, vague, and culturally biased AIDS education programme. Education efforts in ethnic minority areas reportedly include Burmese language posters displayed in places where the majority cannot speak Burmese, much less read it.

Addressing the HIV/AIDS problem in Burma will require an end to the military junta's complicity in the heroin trade, and a change in the miserable socioeconomic conditions in Burma which cause a continued outflow of migrants and refugees to the border areas. Until the HIV/AIDS epidemic is properly addressed, the problem will continue to spread at an alarming rate, affecting huge populations both inside Burma and along Burma's borders.
—*Burma Issues*

Facing the challenge

Dr Myat Htoo Razak is a medical doctor and PhD holder from Burma who specialises in Epidemiology of Infectious Diseases with an emphasis on HIV/AIDS and Health Policy and Planning. He currently works in HIV/AIDS research, prevention, care, and support programmes in Asia through various international agencies and institutions. He talks about the severity of the HIV/AIDS situation in Burma in this interview reproduced from *The Irrawaddy* magazine.

QUESTION: How serious is the HIV/AIDS situation in Burma?

ANSWER: As a health worker and a person from Burma, I would say the HIV/AIDS situation is one of the country's most serious health and social challenges since the late 1980s. The focus has mainly been on how many are infected, as estimated numbers of people with HIV/AIDS in Burma vary. The UNAIDS 2002 report estimated from 180,000 to 420,000 cases, while another group of researchers estimated 687,000 cases. It doesn't matter whether the number is one hundred or one million if little is being done to prevent more infections and to provide care and support to those who are already infected. We need to have good estimates for better planning but

Poor healthcare system worsens HIV/AIDS problem

Health care facilities vary widely in Burma, but options for HIV/AIDS prevention and care are typically very limited. An estimated 35% of Burmese have no access at all to even basic health services. Standards for 'basic' health care facilities are pretty low - everyday medical technology is incredibly scarce in Burma, with many hospitals or clinics having to do without X-ray equipment, microscopes, or even electricity. In places like this, everything available must be reused as much as possible. Many clinics have only one means of sterilising their equipment: boiling water.

In the more urban areas of central Burma, government clinics and hospitals generally have supplies of rubber gloves, some disposable syringes or sterilising equipment, and tests for HIV (as well as malaria, TB, and elephantiasis, which are common diseases in Burma). Even where medical supplies are available, they are expensive and often the patients must pay additional charges for the use of such basics as disposable needles, rubber gloves, and basic medicines. HIV tests are costly and therefore generally used sparingly, only when the patient is considered to be at risk for the disease.

The economic crisis in Burma has hit government employees, including health care workers, very hard. Nearly every physician or health worker works part-time at a separate clinic or other job to supplement their government salary - one town with about 30 qualified doctors reportedly also had 30 private clinics. This probably explains a common complaint that even when hospitals and government clinics are officially staffed, the staff can be inattentive or hard to find.

Because of shortages and the economic pressures on clinic staff, clinics often offer no additional services and no medications at all: the clinic staff just diagnose and tell the patients what to buy and they have to find it themselves, whether it be equipment or medication. For a fever, most people don't bother to go to the clinic; they just find a drugstore where they can get medicine or an injection. Generally, government clinics have no dispensary, but there is usually a privately run profit-making drugstore close by.

With so little medical help available to the patients most at risk for HIV/AIDS infection, there are certainly many people in Burma who carry the virus, and eventually sicken and die from HIV-related causes, who never receive any medical care at all, and may not even know what illness they have.

Those who do receive some medical care often just head to a pharmacy or local healer, and so they receive treatment from people with little or no medical training, and therefore with questionable knowledge in HIV/AIDS prevention. Most medical workers are truly doing their best to care for their patients, and to reduce the risk of HIV/AIDS, but the resources and staff are simply stretched to the limit.—*Burma Issues*

Burma needs to move forward with action now. I deeply hope that people in Burma will soon be able to respond effectively to this serious health, social and development challenge.

Q: What sort of challenges and difficulties are there when gathering data in Burma?

A: Information on behaviour and practices related to sex and drug use is always challenging to collect. People do not usually provide correct information about sexual history and drug use if they don't know how the information will be used and how confidential it will be. Without the availability of reliable HIV testing facilities and confidential pre- and post-test counselling services, information from the community is not easy to collect. Information on HIV/AIDS in Burma comes mainly from the national sentinel surveillance system, which has been conducted by the Ministry of Health since 1992. Currently, there are 27 sites in 14 states and divisions that gather information from selected populations for a one-month period twice per year. The number of tests is limited. One hundred to 600 people are tested at each site during the surveillance period. Whenever such a system is used there is a concern whether the information is a good representation of the situation in the country.

Q: What have you discovered about the prevalence of HIV in the armed forces? Do you have a reliable class breakdown of HIV infections?

A: According to the reports from the national surveillance system of the Ministry of Health, HIV prevalence among new military recruits was 0.4 percent in 1993 and gradually increased every year, rising to 2.5 percent in 1999. A drop was reported between 1999 and 2000, when the percentage decreased from 1.7 percent to 1.4 percent, but it was 2.5 percent again in 2001. The Ministry of Health visited two sites on two occasions (March and September every year), but only tested 600 military recruits on each visit. So, we don't know the actual HIV prevalence among all new recruits or the HIV prevalence among the armed forces personnel as a whole. It would be detrimental for the country not to provide HIV/AIDS prevention, care and support programmes for the armed forces personnel because they are a part of the country. For the sake of the country, ethnic groups, students, artists, entertainers, businesspeople, politicians, military personnel, civil servants, religious groups and all other communities must work collaboratively. The goal must be effective prevention and control of the HIV/AIDS epidemic.

Q: The UK government recently pledged £10 million to help deal with the HIV/AIDS crisis in Burma. How seriously does Burma need international assistance?

A: Every country needs assistance in responding to the HIV/AIDS epidemic. HIV/AIDS prevention, care and support programmes require a substantial amount of money, more than national governments can allocate from their budgets. Ideally, international assistance is intended to allow countries to help themselves after the initial money is given. So, there should not be any 'misplaced pride' (*ta lwal mah nah*) related to receiving assistance as long as the government is serious about using it to benefit the people. It is important to spend a large proportion of the international assistance on programmes that benefit the communities on the ground directly, rather than spending it on international organisations and experts.

The UK government and a few other governments have pledged to provide millions of pounds to Burma through the UN's 'Joint Funding Mechanism'. Although it is good to assist the country through the UN system when other alternatives do not seem possible, the donor agencies and people of Burma will have to make sure that the UN's bureaucratic system is judicious and efficient in this critical task.

It is crucial that the Expanded Theme Group of the UN and 'community advisory groups' make working together a priority when planning and implementing intervention programmes. It is also essential that those groups include different segments of the community and should not exclude members of certain political or ethnic groups. Without active participation of such groups in the decision-making process, the international assistance will benefit those who work with international agencies rather than the people of Burma. In addition, support for ethnic groups and people living in the border areas should be a high priority for donor agencies because of the serious impact of HIV/AIDS in some of these communities. Donor agencies and the international community should also focus on the cross-border aspects of HIV/AIDS prevention and care. There is a desperate need for better mutual understanding between the host countries and migrant communities from Burma to reduce the risks of HIV transmission and to improve access to health care for those who need it.

Q: Can you explain some of the practical concerns for international NGOs and donor agencies in regard to distributing resources and funds?

A: International NGOs play an important role in terms of providing resources and funds to the people. However, their usefulness depends on their objectives, experience, knowledge and commitment to the people. Donor agencies should monitor and evaluate the performance of international NGOs in Burma based on their actions and impact on the ground. I think there are a few good international NGOs working in Burma who can deliver both the financial and technical support provided by the international agencies. However, Burma will have to rely on those international NGOs for a long time if donor agencies insist on working exclusively through them. There are many good civil servants, local community organisations and ordinary citizens who are dying to do—and dying while doing—something good for the country under challenging circumstances. The donor agencies should search for creative ways to support their efforts and enhance their capacity.

Q: Critics say that the government is in denial. Do you believe this is still the case?

A: We have to define the government first to answer that question. I

would like to differentiate between the top SPDC decision makers and the civil servants. Civil servants working in the 'government system' have been reporting on the HIV/AIDS situation in Burma at international forums for many years. If I remember correctly, in the year 2000, a former Minister of Health released a statement mentioning that the HIV/AIDS epidemic was very serious in Burma. And, Gen Khin Nyunt opened the World AIDS Day ceremony in Burma in Dec 2001. So, I think there has been some recognition of the HIV/AIDS situation in Burma by civil servants and the top SPDC decision makers lately. However, recognition does not necessarily translate to an effective response. Burma has lagged way behind neighbours such as Thailand, China and Cambodia in terms of prevention and control of the HIV/AIDS epidemic. There is a saying 'better late than never' but being late has already hurt the country. The people of Burma have the will and the wits to overcome a lot of serious adversity. So, let's hope that people will be able to respond to the HIV/AIDS epidemic effectively in the very near future.

Q: How are patients and their families inside Burma coping with the disease?

A: Only they can tell you how they are coping with the situation. They might be coping with the harsh reality, and hoping for miracles due to the limited availability of health services and social support. Without dramatic improvements in the health care and social support systems, it will be quite difficult for people living with HIV/AIDS in Burma to cope with the situation well. However, like in many countries, people with money and connections might be able to do a bit better than those without. People living in towns and villages far away from major cities will have more severe situations due to less access to health care and financial difficulties. I hope that in all states and divisions there will be a more systematic approach to providing sufficient care and support to people living with HIV/AIDS and their families.

Nurses work under dangerous conditions

The story below is told by a former nurse now living in Thailand. She describes the difficult conditions she had to work under when she was in Burma.

'In Burma, to become a nurse I needed to study for three years. After that, I had to work for three years as a trainee nurse in a government hospital run by the Ministry of Health.

To be part of the full-time staff at any government hospital in Burma, I then had to sign a 10-year contract under which I would be penalised up to 50,000 kyats compensation, paid to the hospital, if I left my position before the contract term was up.

In practical terms, even a nurse who has worked for 30 years is not permitted to resign.

Every nurse is willing to treat the patients well and with good intentions. But practically it is very hard because the hospitals were built with donations from the people but only the hospital building is there — the reality is that there are no medicines available at the hospital.

In the hospital where I worked, there was no antiseptic lotion available for three to four years up to the time I left. So we were forced to ask the patients themselves to buy the antiseptic.

Rubbing alcohol is distributed by the government health department but there is not enough of it, so the staff of the hospital were forced to use boiled water with rubbing alcohol sprinkled in, to give it the smell of alcohol.

No rubber gloves are issued to the nurses and the doctors, so we asked the patients to buy these too, but most of the patients are poor and can't afford these things so the nurses must use torn, old rubber gloves.

After an operation on a patient, these torn gloves are sterilised and used again. The hospital does not have the money to use disposable syringes either, we must use the reusable syringes that we are issued.

The staff at my hospital did not want to be involved in corruption so we didn't ask the patients to give us money to buy these things.

Instead, we asked the patients and their families to buy the things we needed themselves, and then give them to us. Therefore, the patients had to spend a lot of their own money.

For example, a circumcision cost a family about 3,000 kyats. A caesarean section cost about 15,000 kyats. A major operation might cost the patient about 50,000 kyats.

In the hospital, I saw many cases of venereal diseases, but I don't know about HIV/AIDS because there was no way for us to test for HIV infection.

So the nurses who worked in the operating room, like when a baby was being delivered, were facing dreadful diseases that they were unable to protect themselves against.

The death rate of newborn babies, and the incidence of deformity in infants, and the number of malnourished babies were increasing during the time I was there.

Most of the nurses I worked with want to resign. Many nurses in the army resigned and tried to find a way to work in foreign countries.... We nurses felt that we were at risk, being exposed to dreadful diseases, and were in as much danger as soldiers.

So we thought we should get protective devices for our work like gloves, sufficient food, and adequate rest between our shifts.

When I was there working at the hospital, the nurses wanted to do a good job and always had good intentions toward the patients. The major problem we faced was not getting enough salary and facing dangerous working situations.'

— *Burma Issues*

Act now on AIDS, UN urges Asia

The United Nations has called for immediate wide-ranging action to prevent Asia emerging as the epicentre of a global HIV/AIDS pandemic in the next decade.

Joy Phumaphi, UN secretary-general Kofi Annan's HIV/AIDS commissioner, told a regional World Health Organisation meeting in Manila in September 2003 that a comprehensive plan was needed urgently to halt the virus in its tracks.

'You have to have a full-scale, multi-sectoral, fully-integrated aggressive intervention now. That is my message to you, it is absolutely critical,' Phumaphi said.

Phumaphi, who hails from Botswana, which has the world's highest HIV/AIDS infection rate, said the action was needed to prevent forecasts Asia would witness an explosion in cases in the next decade.

'I come from Botswana and I came here to share our experience because I don't want you to fall into the same trap that we fell into,' she told top health officials from 37 countries attending the WHO Western Pacific annual meeting.

She said Botswana had once thought HIV/AIDS was limited to a certain high-risk group only and that emphasis on prevention and moral values was effective enough to control the spread of the epidemic.

'And what we are seeing now is that 39 per cent of pregnant women are infected by the virus. This epidemic is a moral, socio-economic, political and security imperative for the whole global community.

'No half measures will work. The extent and long-term effects of the impact on society or on economic growth [are] not temporary. You are going to experience considerable loss in the gains that you have made over the years.

'You are going to experience a situation where your investment in human capital is going to come to naught,' warned Phumaphi, a former Health Minister of Botswana.

Other officials warned of the danger of a wider HIV/AIDS epidemic gripping East Asia and the Pacific as significant increases in sexually transmitted infections continue to be recorded, particularly among young adults.

High-risk behaviour is increasing in the Western Pacific region where about 1.2 million people have HIV, said WHO, citing growing levels of infections, particularly in Mongolia, the Philippines and Pacific island countries.

Surveys in China, Malaysia and Vietnam show that the percentage of intravenous drug users selling sex is increasing in all three countries.

Evidence suggests this is facilitating the spread of HIV into the wider community, WHO warned.

Phumaphi also called for routine testing for HIV/AIDS among the public and mandatory school lessons on the disease in the region.

'In order for everyone to know their status, you need routine testing now in your health systems. Do not introduce HIV/AIDS programmes as vertical programmes. There must be integration now.'

— *AFP* in *New Straits Times* (M'sia), 12 September 2003

Filipinos bring AIDS home

Carlos H.Conde

While AIDS prevalence in the Philippines is relatively low, AIDS experts and monitors are concerned that the situation could worsen if nothing is done about the increasing number of overseas Filipino workers who are carrying the disease back home.

Already, the United Nations Programme for AIDS has warned of a 'huge explosion' of the AIDS epidemic in the Philippines, citing, among others, the vulnerability of these overseas Filipino workers.

The country's economy, after all, is kept afloat by the money sent back home by an estimated seven million Filipino workers all over the world. In 2002, the total remittance was $7.19 billion, most of it coming from workers in the United States.

According to figures released by the United Nations Programme for AIDS in the middle of 2003, only one overseas Filipino worker in 1984 was found to have been infected by HIV, the virus that causes AIDS. In 2002, 97 were reported infected.

As of mid-2003, the UN agency recorded a total of 583 Filipino overseas workers with the virus. In 2001, the number was only 458; by the next year, it was 546 – or 30 percent of the 1,796 total AIDS cases that year.

The official registry of the Philippine Health Department puts the number of AIDS cases in the country under 2,000, while the UN agency estimates that it is thousands more, perhaps more than 9,000.

Dr. Michael Tan, a medical anthropologist at the University of the Philippines who has studied the AIDS situation in the Philippines, said AIDS among overseas Filipinos might fuel the epidemic that the United Nations Programme for AIDS had warned about. Often, these Filipinos work in countries with much higher prevalent rates.

Of all the overseas Filipino workers, seafarers have the largest number of AIDS infections.

They are also some of the least educated about the disease. A government study released in August 2003 indicated, for example, that, of the 420 seafarers surveyed, only 28 percent to 38 percent 'knew that mutual monogamy, consistent condom use and consistent use of clean needles and syringes prevent HIV transmission'.

According to the study, 34 percent of them had sex, mostly with prostitutes, during their last tour of duty, and 85 percent had sex in the Philippines upon their return from that tour. In 2002, there were more than 200,000 Filipino seafarers abroad.

When an infected overseas worker returns home, he can easily infect his spouse, who may avoid asking any questions about her husband's sexual behaviour abroad lest she be accused of questioning the integrity of the person who toiled to support his family back home, Tan said.

— *International Herald Tribune*, 1 December 2003

All about AIDS in China

♦ AIDS began in the late 1980s among injecting drug users (IDUs) in Yunnan.

♦ Studies suggest that IDUs are more sexually active than the general population and are more likely to have multiple partners, including commercial partners.

♦ There may be 6 million IDUs in China now; 17% are women, of whom up to 50% may sell sex, or about 500,000 women.

♦ Sex workers are seen as the main potential 'bridge population' to the wider public.

♦ Transmission has also been through blood products. In Henan, China's most populous province, at about 100 million or more, the outbreak was discovered in 1995. According to one report, Henan had 280 commercial blood product collection points, licensed by local health authorities. Mostly rural, uneducated and poor, the people had little or no access to education, health care, and other services, and couldn't protect themselves against HIV/AIDS. Infection rates are as high as 60% in some villages, according to unofficial estimates.

♦ Condom use among female and male sex workers is low or intermittent. There has been a significant rise in HIV infection rates among sex workers, according to China's UN Theme group on HIV/AIDS. In Guangxi, 9.9% of surveyed sex workers tested positive in the third quarter of 2000, rising to 10.7% in the fourth quarter; in Yunnan, it rose from 1.6% to 4.6%; and in Guangdong, from 1.2% to 3.0%.

♦ Reported cases of sexually transmitted (STIs) diseases rose from 200,000 in 1991 to 850,000 in 2000. (It's generally thought that the actual STI cases are at least 3-4 times the number reported.) STIs and other reproductive tract infections are known to be very common among rural women.

♦ Recent interviews with sex workers in Shanghai, Sichuan and Yunnan reveal a high level of ignorance, such as: HIV+ clients have 'black genitals'.

♦ One survey conducted by Future Group Europe in collaboration with Chinese government research agencies suggests that HIV/AIDS will reduce annual GDP by RMB 14-21 billion by 2010.

— *Oxfam Magazine*, 2003 No.1

Sources: *China Development Brief*, Volume V, Number 1, Spring 2002; *China Rights Forum*, No.3, 2002

China's 'titanic peril'

Since 1994, when the Chinese Government signed the Paris Declaration at the International AIDS Summit, some significant progress has been made with regard to updating national policies, laws and regulations in various areas pertaining to HIV/AIDS.

However, many factors remain that hinder an effective AIDS response in China. These factors are often closely inter-related. They include insufficient political commitment and leadership at many levels of government, insufficient openness when dealing with the epidemic, insufficient resources both human and financial, scarcity of effective policies, lack of an enabling policy environment, and poor governance.

AIDS awareness remains low among the public and decision makers. Involvement by civil society and affected communities remains embryonic, while the overall AIDS response remains far too medical within a health care system in crisis.

— *Oxfam Magazine*, 2003 No. 1

Samizdat action

A jerkily shot samizdat film circulating in Beijing tells two stories about modern China. It was put together by a group of university students who visited Henan's 'AIDS villages' to interview the dying. One by one, the hapless farmers who sold blood to the plasma factories in the 1990s face the camera and share their misery with us. They tell of family members lost, of fields untilled. They pull back their clothes to display rashes and sores, and hold rotting fingernails up to the lens. There's no money for medicine, no money for funerals, often no money for clothes or even food. (According to UNDP, the numbers of absolute poor in two of the worst affected counties, Shangcai and Xincai, rose from 99,000 and 41,000 respectively in 2000 to 265,000 and 270,000 in 2001, representing around a quarter of the total population.) They appeal, with pitiful diffidence, for government leaders to pay a little bit of attention, give a little bit of help. And they break down in tears, one after another, for two of the most harrowing hours in Chinese documentary history.

That is the seemingly hopeless story. The more promising story, or subplot, is that the students were brave and determined enough to make and circulate this sorry epic.

— *Oxfam Magazine*, 2003 No. 1
Source:(excerpt) *China Development Brief*, Volume V, Number 1, Spring 2002

PNG: AIDS threat from 'big men'

A Papua New Guinea woman told a seminar that her husband was paid more than K1.8 million by the Government after being hired as a consultant last year. The seminar also heard that many politicians, senior bureaucrats and businessmen were customers of sex trade, found to be one of the main sources for transmission of HIV in this country.

Seminar participants expressed the need for something to be done about 'big men' taking more than one wife and being the focal point for transmission of HIV to their wives, and eventually to their children. The woman, from West Sepik Province, said her husband, also from her home village, was an example. He left her and their children in Australia and had taken leave from his job in Australia to come back to PNG under a contract with the PNG government. — *PostCourier/ PINA www.pacificislands.cc*

AIDS problems in China

The social costs and stigma of AIDS in China are scarcely being addressed. Villagers in Dongguan in Henan province estimate that as many as 100 children have lost one or both parents to AIDS or live with a parent dying of the disease.

While villagers say the government gives the families two sacks of flour a year and a small discount on school fees, children of HIV-positive parents are often segregated at school.

The precise number of people with HIV or AIDS in China is a matter of debate. Chinese officials estimate that roughly a million people have died of AIDS or are HIV-positive. Some experts, though, suspect that Henan, with nearly 100 million people, may itself have a million cases. A recent story in the official news media, by contrast, estimates that Henan has about 35,000 cases.

There is no doubt that the province is an epicentre. In the early 1990s a blood-selling campaign promoted by local officials as a means for people to earn money caused mass HIV infections. Villagers, barely scratching by in one of China's poorest regions, repeatedly joined in.

Lin Degui said he had sold blood 10 or 12 times a month. He and his wife used the money to pay for his son's wedding. His wife is now dead, a victim of AIDS. His son is HIV-positive.

Zhao Sanmin, who was born without a left hand, said he had sold blood because as a handicapped man he needed money to attract a wife.

— *International Herald Tribune,* 22-23 November 2003

Malaysia and Singapore: Ill-prepared to stop a growing AIDS epidemic

Johan Fernandez

There are only about 10 doctors throughout Malaysia who have significant experience treating HIV/AIDS and the country will be ill-prepared to thwart a growing epidemic, with indications that the infection rate is going up.

According to *TREAT Asia Report*, a quarterly newsletter published by the American Foundation for AIDS Research on behalf of TREAT Asia (Therapeutics Research, Education, and AIDS Training in Asia), the rate was rising, especially among injection drug users and female sex workers in urban areas. Compared with many South East Asian countries, Malaysia, however, had a relatively low prevalence of HIV/AIDS.

Dr Adeeba Kamarulzaman of the University Malaya Medical Centre (UMMC), a top health expert on HIV/AIDS, attributed the shortage of experts in Malaysia to doctors tending to shy away from specialising in infectious diseases and opting instead for more lucrative fields like dermatology and ophthalmology.

Another reason was the high level of stigma associated with HIV/AIDS. She said that Malaysians traditionally condemned activities that could lead to the transmission of HIV, including intravenous drug use, premarital, extramarital and homosexual sex, and sexual relations with sex workers.

While injection drug users represent the majority of the cases, Dr Adeeba said they made up only 15% to 20% of patients who came to the unit. Most of her patients contracted HIV through heterosexual sex.

— *The Star* (M'sia), 15 July 2003

Hotel accused of discrimination

Bangkok: Thai AIDS activists accused a hotel here of discrimination against HIV-positive people, just three weeks before some 20,000 delegates are to converge here for a global forum on the virus. The activists said staff at the unidentified four-star hotel had moved people with HIV who were at a conference on HIV/AIDS it hosted this month to a single, isolated floor and cordoned off a dining area to separate them from other guests. – *AFP* in *The Star*, 18 June 2004

Singapore records highest ever AIDS cases

Singapore last year recorded the highest number of new HIV/AIDS infections since the disease first appeared in the country in 1985, its Health Ministry said on 17 May.

A total of 242 people were diagnosed with HIV/AIDS in 2003, exceeding the 2001 high of 237 new infections.

The latest statistics indicate that 'prevention efforts have failed', said Brenton Wong, vice president of the Singapore-based Action for AIDS advocacy group.

Most of the infections were reported by single heterosexual men and acquired through sexual transmission, the statistics showed.

Women reported 30 of the 242 new infections.

– *AP* in *The New Straits Times* (M'sia), 18 May 2004

UN warns India on AIDS

India announced a sharp rise in its number of HIV/AIDS cases in July 2003 after the United Nations warned New Delhi it must ramp up efforts to fight the disease to avoid catastrophe.

National AIDS Control Organisation project director Meenakshi Datta Ghosh said some 4.58 million Indians were living with HIV/AIDS at the end of 2002, a significant leap over 3.97 million in 2001.

India, with a population of more than one billion, has the second largest number of people living with HIV/AIDS after South Africa, UNAIDS executive director Peter Piot said.

'Political leadership is vital to turning back the HIV/AIDS epidemic rapidly spreading in Asia. India and China have a large population and economy. The region is looking for leadership from these two countries and Indonesia,' Piot said.

— *The Star* (M'sia), 26 July 2003

HIV/AIDS: Russia's underrated epidemic

Tatjana Bateneva & Torsten Brezina

AIDS in Russia can be traced to the drastic changes that took place when, together with Eastern Europe, the former Soviet Union under free market reforms dismantled the welfare state with cuts in health services, education and employment, resulting in deteriorating human outcomes. Life expectancy fell in some of the countries. Russia is now experiencing negative population growth.

Economic reforms and structural adjustment programmes have been responsible for the disintegration of civil society. Economies have stagnated. Between 1989-96 inequality doubled, wages fell by 48% and serious human deprivation resulted. There are extremes of grinding poverty and unsatiable affluence in society. Prostitution, drug taking, alcoholism and violence are flourishing. Young people do not see hope for the future. Homicides and drug trafficking have increased, and illegal human trafficking is a major social problem; some 500,000 women are trafficked each year for sexual exploitation from Eastern Europe to Western Europe — a reflection of the economic inequalities that have resulted from free market reform. It is against this backdrop that the HIV/AIDS crisis has developed.

As of 1 October 2002, a total of 215,304 people in the Russian Federation were officially registered as living with HIV. International organisations such as UNAIDS and WHO estimate that the true number of infections is four times greater, meaning that almost 900,000 people in Russia have HIV. The explosive increase in infections since the end of the 1990s is especially worrying. In 1998, a total of 10,993 people were officially registered as HIV cases. In 2001, the number of new infections alone totalled 83,000. As a whole, the number of registered HIV cases has risen by 20 times since 1998. Russia has the highest increase rate worldwide.

The main risk group are drug addicts. The majority of infections in Russia, totalling more than 80 per cent, are transmitted by injecting drug use (IDU). That is a top value; according to the UN, the global prevalence rate among such groups is only 5-10 per cent.

The spread of HIV in Russia is not limited to big cities and central regions. A typical example of cases outside major urban areas is the village of Kamysjak of 8,000 inhabitants on the Lower Volga, far from cities and the country's major roads. In 1999, 30 new HIV cases were registered there within only a few weeks, all involving young people aged 15 to 27. They had taken up drug use together, injected themselves regularly as a group, and often shared a needle or a prepared sub-stance.

The first official HIV case in Russia, a Soviet development aid worker who had spent many years in Southern Africa, was registered in 1987. Russian and international specialists warned at the time that widespread education work, especially among young high-risk groups, was urgently needed. A law on the rights of people living with HIV was passed and a network of state centres for preventing and combating AIDS was set up. There are now such centres in every region and all big cities. But due to a lack of money they restrict their work almost solely to registering and caring for people already infected with HIV.

Free market and social collapse

The radical processes of social change triggered by *perestroika* were and still are marked by a rapid growth in drugs use. Due to the partial withdrawal of the state from its responsibility for education and healthcare, the break-up of family ties and a general ideological crisis, the general conditions for healthy behaviour by the people were decisively worsened. Against this background, children and teenagers are a particularly endangered group. Often, they are unable to cope with difficult situations in life. In addition, they lack role models or their parents have no ideas about their upbringing on which the young people could orient themselves amid new problems. These conditions are the breeding ground for continually growing consumption of drugs and alcohol among young people. And the use of drug injection needles by several persons increases the risk of infection with viruses.

Whereas the first wave of HIV infections paved its way mainly in the homosexual milieu and in hospitals (via blood transfusions), the second strong wave is linked with an extreme increase in drugs use. This wave is now being overlaid by a third. The number of new infections transmitted by heterosexual intercourse is growing steadily. However, in the social debate the subject of AIDS is still seen largely as a problem of marginal groups. Most people do not recognise that AIDS and dealing with it will increasingly become part of daily life.

There are now initial signs of change. For 2002 the state programme of measures to combat the spread of AIDS (ANTI-HIV/AIDS) was for the first time fully financed

with 183 million rouble (about 6 million euros). In earlier years, at best only 10 per cent of the funds applied for were approved. In addition, Russian President Vladimir Putin has created with much media coverage a financially well-equipped 'President Programme' to promote mass sports for children and teenagers aimed at general good health.

But concrete work in Russia on preventing HIV is now done mainly by NGOs. Promoted by international organisations such as UNICEF and Doctors Without Borders, they realise projects to improve the knowledge of children and teenagers about HIV/AIDS and measures to prevent infection. That includes education campaigns, the training of 'peer educators', distribution of print and video material on AIDS and drugs, and staging concerts and sports actions. The range of the measures is good in qualitative terms, but completely insufficient in quantity.

In Kamysjak, experts from the regional AIDS centre are currently implementing a 'harm reduction' programme. One of the programme's simplest but most effective measures was exchanging used drug injection needles for new, sterile ones. A mobile needle exchange centre visited the village. The action was run mainly by volunteers from the non-profit 'We Young People' of the Astrakhan youth newspaper of the same name. They included many people who themselves are affected.

The change from being a passive victim of HIV infection to becoming an active fighter against negative social situations can now be seen more and more in Russia. The political acceptance of such activists is so far low. Politicians cannot win votes with issues such as HIV/AIDS and drugs. But if the present scale of the epidemic should grow further (and that must be expected), it cannot be excluded that a movement of people living with HIV will arise. Its leader would represent the interests of the infected and their families. The almost one million HIV-positive people in Russia are already a real force who defend their own rights. – *Development & Cooperation* (Vol. 30:2003:2)

AIDS spreading rapidly in Eastern Europe

Sanjay Suri

Eastern Europe is seeing the fastest-growing AIDS epidemic in the world, studies by UN agencies show.

AIDS is also on the rise again in Western Europe, causing new concern about the spread of the infection in areas thought relatively safe, new data shows.

'Across Eastern Europe and the Central Asian Republics, the number of AIDS cases has grown from 30,000 in 1995 to 1.5 million now,' Dr Gudjon Magnusson from the World Health Organisation (WHO) told IPS on 23 February. 'That is a 50-fold increase in eight years'. The Baltic states are also experiencing a rapid rise in HIV infections, the studies show.

'In Western Europe the incidence has risen to between half a million and 600,000 cases,' Magnusson said. 'The infection in Western Europe began in the 1980s, and in Eastern Europe around the mid-1990s, but the incidence there is already three times as high as Western Europe'.

The numbers are still small compared to the worldwide incidence of an estimated 40 million cases, with about 27 million of them in sub-Saharan Africa, Magnusson said. 'But we are concerned about Eastern Europe and the Central Asian Republics because it is rising so rapidly here'.

It is particularly worrying that 80 percent of the infected people in this region are below 30 years of age, Magnusson said. Seventy percent are believed to have contracted AIDS through injecting needles while taking drugs.

At the root of the spread is 'poverty, unemployment and lack of faith in the future', Magnusson said.

'We are also trying to secure more funding and to improve health and education capacity,' he said. Most of these countries have an infrastructure in place unlike many areas of Africa, and therefore levels of knowledge and treatment could be improved in a relatively short time, he said.

'AIDS is a European problem,' UNAIDS executive director Dr Peter Piot said. 'Of all the social and political challenges facing an expanded European Union, AIDS is one of the greatest, requiring determined and sustained action now'.

The countries facing the epidemic are now on the borders of the European Union (EU) after its expansion on 1 May.

A large number of the young in Eastern European and Central Asian countries also engage in unsafe sex, warned a statement released by a 23-24 February conference in Dublin which highlighted the spread of AIDS in Europe. 'There is also evidence that people are having sex at a much younger age without protection. The percentage of people reporting premarital sexual relations more than doubled between 1993 and 1999, from 9 percent to 22 percent. Only 10 percent of girls in Tajikistan have ever heard of HIV/AIDS'.

In many countries of Western Europe too, there are increasing rates of sexually transmitted infections, indicating resurgence in unsafe sex, primarily among young heterosexuals, the report says.

In Western Europe most people have access to free treatment through national health systems, but 'many governments have not focused as much on prevention as they did in the 90s', the statement says. 'Infection rates are once again on the increase'. But Europe cannot be divided over the issue of AIDS treatment and only provide treatment in the richer countries, WHO director-general Dr Lee Jong-wook told the Dublin conference. 'Treatment should be a right for all, including for sex workers and injecting drug users'. — *IPS*

AIDS in Latin America advancing slowly but steadily

Paula Andaló

There is a potential for the disease to become a serious threat if effective preventive measures are not taken. However countries in the region are stymied by poverty, lack of resources, poor infrastructure and health systems and unaffordable medicines.

HIV has proved itself largely non-discriminatory, affecting both rich and poor (particularly in the first years of the epidemic), strong and weak, children and adults. Passing through entire continents unseen in the microscopic spaces of cells, it has followed a relentless logic in producing epidemics: Wherever, whenever cracks appear in a system, the virus will seize the opportunity to invade.

'It happens whenever a country's socioeconomic order is affected, as in the case of many African countries and in the former Soviet Union,' says Fernando Zacarias, chief of the HIV/AIDS unit of the Pan American Health Organisation (PAHO). 'Wars, crises, induced migrations, major breeches in the health system, these generate ideal conditions for HIV to expand.'

Will the same laws hold in this hemisphere? In North America, nearly 1 million people are believed to be living with HIV. In Latin America and the Caribbean, an estimated 1.9 million adults and children are HIV-positive. This includes 210,000 people who contracted the virus in 2002; it does not include the estimated 100,000 people in the region who died of AIDS the same year.

Zacarias recalls that 20 years ago, when some people referred pejoratively to AIDS as the 'pink plague' and the virus itself was a recently solved mystery, the future looked apocalyptic. 'There was an international survey of experts, and our vision was terrifying. We imagined a year 2000 completely devastated by the disease.'

Time and medical research have demonstrated that the infection can be transformed into a chronic disease, that many can remain HIV-positive without developing AIDS and that the planet will not be decimated. But the battle against AIDS requires clear health policy decision making and political commitments.

'The war is only beginning,' Richard Feachem, director of the Global Fund to Fight AIDS, Tuberculosis and Malaria, wrote in a January 2003 op-ed piece in *The Washington Post*.

In Latin America and the Caribbean, the AIDS epidemic has until now followed a slow but expanding path. Prevalence rates in some Caribbean countries are among the highest in the world after sub-Saharan Africa. In the two decades since the start of the epidemic, Latin America has undergone wars, sociopolitical crises and system breakdowns. Yet the epidemic has not exploded as in other regions.

Zacarias explains the difference citing genetic as well as social and cultural factors: 'There are currently two major groups of HIV circulating in the world, HIV1 and HIV2. We already know of 10 subtypes of HIV1 and five subtypes of HIV2. It so happens that in the Americas, the strain that is circulating is the same one that is circulating in Western Europe — HIV1, subtype B — and it is apparently less virulent than the HIV2 strains that are circulating in Africa.'

Not only are the African strains of HIV more pathogenic, they are also more easily spread heterosexually, which partially explains the accelerated pace of Africa's epidemic, says Zacarias. However, the virus mutates so readily that the relatively favourable scenario in the Americas could easily change in the coming years.

Zacarias notes with approval that many countries of the region took the threat of this 'new disease' very seriously as early as the beginning of the 1980s. 'In Brazil, for example, there were from the outset clear decisions at every level — ministerial, public health, in the communities,' he says.

'Through effective campaigns and interventions they were able to slow the progress of the epidemic. Also, in Cuba, they took drastic measures, which were strongly criticised, but they managed to keep the virus out of the island during the first years of the epidemic'. In today's world of travel, tourism and globalisation, however, he and others insist that such 'epidemiological fences' will no longer work.

Women most vulnerable

The UNAIDS report for 2002 notes that one factor favouring the spread of HIV in Latin America and the Caribbean is the combination of inequality and a highly mobile population. For Zacarias, it is behaviour that has most influenced the evolution of HIV in the region. 'Heterosexual transmission is emerging as a major mode of infection. And the most recent target of the epidemic is women, particularly monogamous women who are infected by their own partners, who in many cases are having sex with other men. What happens is that the chain of contagion stops there, in the wife or girlfriend.' In other words, what is slowing the epidemic is basically a cultural phenomenon.

In 2001 the slogan for UNAIDS's world campaign called on men to

PAHO

In Latin America, the epidemic's most recent target is women who are infected by male partners who may be having sex with other men.

'make a difference'. Far from endorsing male control over sexual relations, the campaign was instead appealing to men to be conscientious about using condoms to protect themselves as well as their partners. Using a condom was in a sense assuming personal responsibility in the battle against AIDS.

This is no arbitrary approach; condom use continues to be critical in preventing infection. But it is also something over which many women have little control. 'In some countries women are not given the status to be able to make their own decisions about safe sex,' says Fauci. 'We have to continue to educate everyone from the leaders of the countries down to the people who are the community leaders in order to make the changes that we need.'

In South Africa, where one out of four people is infected, a tribal king can have dozens of children and several wives. Will a king use a condom? Will a Latin American truck driver who delivers goods in several countries? Or the small farmer from China's Jilin province who donates blood once a month for his only steady income?

Zacarias believes in the importance of education but adds that, to educate, one must do it in the language and culture of the target group. 'In Haiti, we've done campaigns where a voodoo priest explains, in his own language and rituals, how to properly use a condom. Interventions should be aimed at new cohorts, the newly vulnerable groups, mobile populations — there are many in our continent — sex workers, assembly plant workers and indigenous groups, where the virus has expanded dramatically. The Garifuna population of Honduras has from 15 to 20% prevalence of HIV.'

So where on the AIDS road map do we now stand? The experts agree: We are at a crossroads. It is the perfect time to do things right, to take the correct path to make sure that the epidemic does not explode.

Zacarias' main concern is, what will happen when HIV stops being a problem in the rich countries?

Doing it right

Many nations of the Americas have accepted the challenge of AIDS head on. One example already mentioned is Brazil. 'What Brazil did serves as a model.' They have excellent vision at the top. The country's political leaders and leaders in health realised very early on that it is important to link prevention with treatment, to provide access to treatment throughout the country, to try and overcome in a creative way the obstacles to the availability of very expensive drugs, making those drugs generic and that way available for people with low incomes. They have shown leadership, creativity and concern. They didn't deny the problem; they faced it.

The 2002 UNAIDS report also cites Brazil's policies on intravenous drug users as exemplary: 'Brazil has adopted a less punitive approach to dealing with the dual challenge of injecting drug use and HIV infection — to good effect. Prevention programmes among injecting drug users have contributed to a substantial decline in HIV prevalence in this population in several large metropolitan areas. In addition, a national survey has shown increasing condom use among injecting drug users (from 42% in 1999 to 65% in 2000) – a sign that sustained education and prevention efforts are bearing fruit.'

Another key element in slowing the region's epidemic has been organised advocacy by self-described 'seropositives'. The Latin American Network of People Living with HIV/AIDS coordinates seven regional advocacy networks that work closely with governments, non-governmental organisations and international agencies fighting AIDS. 'Horizontal cooperation has made it possible to win many battles, especially against discrimination and high drug prices,' says Javier Hourcade Belloq, regional secretary of the network.

Zacarias notes that 'with the new antiretroviral therapies, fewer patients go on to develop AIDS, and the number of hospitalisations in the countries has declined significantly'.

'The new generations of men who have sex with men do not have the same perception of the danger to them,' says Zacarias. 'They know there is good medication, that the infection can be treated. But we must keep telling them, it is always, always best not to become infected.'

He proffers the following: 'This process of stabilisation of the epidemic, I might not be around to see it myself, but it can be achieved. In the general population the culture of sexuality is changing. Young people who became sexually active in the AIDS era know it is essential to protect themselves. The key words are care, prevention and treatment.'

Paula Andaló is a journalist at the Pan American Health Organisation in Washington, DC. The above article is reproduced from *Perspectives in Health*, Vol. 8 No. 1. 2003.

The Global Fund and treatment access in Latin America – A critical view

In Latin America, the much-touted Global Fund for AIDS, Tuberculosis and Malaria which makes ARV drugs available for HIV/AIDS-infected people has come unstuck. In the following articles, *RICHARD STERN* critically examines the situation in Latin America.

The Global Fund offers promises and hope for many, but a view from the field in Latin America and the Caribbean indicates that when it comes to antiretroviral treatment access, the complications are many and the promises offered by the Fund are slow to be fulfilled.

In Ecuador and the Dominican Republic, prolonged internal disputes involving the Country Coordinating Mechanisms (CCMs) and Principal Recipients have meant that even though their proposals were accepted by the Fund in January 2003, the grant agreements had still not been signed as of late November, and thus no money has been received. These countries compounded the problem by deciding to wait for Global Fund money to arrive before starting to purchase antiretrovirals for targeted populations. Thus, ironically, the existence of the Global Fund has actually delayed treatment access in these countries.

There is another problem, somewhat less dramatic, that has occurred in almost every country. NGOs that in the past might have tackled violations of human rights or gaps in treatment access now have to consider whether such activism could cause them to lose access to Global Fund revenue received by their local CCM. It is important to remember that in Latin America, prior to the Global Fund, only very minimal amounts of financial support have been available for civil society through national AIDS programmes. The Global Fund appearing on the scene represents a potential 'windfall' of resources, and the dynamics related to advocacy have changed considerably. The key factor here is that most CCMs are, in fact, government controlled, even if that is not the Fund's intention.

The domination of government in CCMs was dramatically illustrated in the Latin American/Caribbean Regional Meeting that the Fund held in Panama last November (2003). Incredibly, only eight of 160 participants were People Living with HIV/AIDS (PLWAs). The Fund had instructed CCMs to make their own selection as to who to bring to the meeting, and only four out of the 20 countries present – Costa Rica, Bolivia, Colombia and Cuba – actually included PLWAs in their delegations.

One of the most interesting moments in the Panama meeting occurred on the final day when nearly a dozen international agencies marched to the podium to present themselves. Among them were USAID, PAHO, GTZ, UNAIDS, the World Bank, the Interamerican Development Bank, UNDP and UNICEF. Many of the agencies made references to the hundreds of millions of dollars they have invested in the AIDS pandemic. After the speakers had concluded their presentations, Julio Cesar Aguilar, a PLWA from Bolivia, commented, 'I am grateful that almost all of the agencies on this stage are working to help us in Bolivia. But I wonder how it is possible that as yet not even one PLWA in my country has received ARV treatment?'

Eighteen months after the Fund began operations, Global Fund money has only led to some 800 to 1,000 people receiving treatment in Latin America and an additional 1,000 in the Caribbean. Most of these are in Honduras and Haiti, which had their proposals approved in Round One, and some are in El Salvador. (Argentina and Chile may also be providing some ARV access with funds provided by the Fund, but ARV access in these two countries was nearly universal even before the GF began to provide funds.)

With the impending arrival of Global Fund money, it seems almost inevitable that there is intense competition and distrust between civil society and government, as well as between NGOs themselves. In two of the countries mentioned above, the fight about who was to be the Principal Recipient was taken by NGOs to the Fund's mid-level staff, and perhaps beyond, and this has resulted in delays which will set the process of actual disbursement of funds back as much as a year. Those who urgently needed ARVs in 2003 will now have to wait until 2004. As many as 25% will not survive.

Another problem is that in some countries, NGOs which represent vulnerable populations such as gay/lesbian/bi/trans people are routinely denied legal registration, yet CCM regulations stipulate that only legally registered NGOs can benefit from Global Fund money. So, because of this Catch 22, these groups – which have a real ability to reach out to and conduct prevention work among their own populations – are supplanted by legally registered NGOs that suddenly appear on the scene and have no demonstrated track record in working with vulnerable populations.

Another discouraging factor is

The Global Fund was supposed to help the poor and vulnerable gain access to anti-AIDS drugs. But a host of problems have meant that those who urgently need the medicines have to wait and may die because of delays.

that some of the accepted Global Fund proposals in the Latin American region were written by highly capable experts who joined forces with local CCMs only for the purpose of writing the proposal. In these cases, the accepted proposal does not always accurately reflect the country's national AIDS programme or its ability to put large amounts of money to good use in AIDS programmes. Some proposals reflect mainly the writing and technical skills of the outside consultants who drafted the proposals.

Another issue is that the few civil society representatives on the CCMs often are well intentioned but poorly trained regarding more technical issues of programme implementation and medication purchase. Many of the PLWA representatives come from backgrounds where they simply have not been trained in the necessary areas. This puts them at a tremendous disadvantage when facing government AIDS bureaucrats who may dominate decision-making processes in areas to do with ARV access and other 'technical' issues.

The only feasible solution to the problems elaborated above would be greater active participation of the Global Fund in CCM activities and programme implementation. The Fund is reluctant to do this because it has limited staff and it wants local capacity to develop and national AIDS programmes to become self-sufficient. One possibility would be for this to happen in phases with, at first, much more support from trained experts whom the Fund could employ after a proposal has been approved.

To suddenly present a previously impoverished and not particularly well-trained AIDS programme with the prospect of millions of dollars is certainly well intentioned but can sometimes lead to all kinds of unforeseen problems, ranging from inadequate infrastructure to rampant manipulation and corruption. People living with HIV/AIDS need treatment today, not in a year or two. But without more active guidance and 'hands on' participation from the Fund, situations that are destructive and lead to long delays in treatment access will undoubtedly continue to occur.

Richard Stern (*rastern@racsa.co.cr*) is Director of *Agua Buena Human Rights Association* (*www.aguabuena.org*), based in Costa Rica. He travels widely in Latin America working with community groups on HIV/AIDS treatment issues.

Global Fund bureaucracy results in more needless deaths in Guatemala

Although Guatemala's $41,000,000 Global Fund (GF) proposal for AIDS, Tuberculosis and Malaria was approved in Round 3 in October of 2003, obstacles placed by Global Fund policies have resulted in a process that may delay release of funds for up to six more months, resulting in the needless death of hundreds of people who need anti-retroviral treatment now.

In Guatemala, the public health system is providing anti-retrovirals to only 200 people of an estimated 4,000 who need ARVs, and the non-governmental organisation Doctors without Borders treats another 600. According to Guatemala's Global Fund Proposal, the funds provided by the accepted project 'will provide anti-retrovirals to an additional 4,381 people during the five-year project'. During 2004, 472 people would receive anti-retrovirals and an additional 1,240 would receive treatment for opportunistic infections, still frequently unavailable in Guatemala. An additional 1,036 would receive ARV treatment the second year, rising to the final total of 4,381 by the end of five years.

However, the Global Fund would not accept the Guatemalan Country Coordinating Mechanism (CCM)'s choice of 'Principal Recipient', which was the United Nations Development Programme (UNDP). The Principal Recipient (PR) is the organisation that receives the funds from the Global Fund and disperses them to government programmes and NGOs according to a series of guidelines. Given the amount of money involved, the Principal Recipient must be an organisation, which has an infrastructure capable of managing large sums of money effectively, and must also be knowledgeable in the field of AIDS. Generally the Principal Recipient charges a reasonable percentage of the project to fulfil these responsibilities. UNDP in Guatemala would have charged 4%, which is apparently very typical of what other PRs are charging in other countries.

Guatemalan CCM members appealed to the GF Secretariat regarding the original decision, and the Secretariat was apparently willing to accept UNDP as Principal Recipient for the first year of the project, but Global Fund Executive Director Richard

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Feacham apparently vetoed the idea.

The only option remaining for the CCM has been to develop a complicated application for other agencies to apply to be the Principal Recipient. The document, when finished, will include a description of responsibilities, terms of reference, and other details. When the document is completed, a 'licitation' process will begin which consists of sending out the document within the country and receiving and evaluating applications made by local agencies. Agencies that already work in the AIDS field and would be potential beneficiaries of Global Fund money will be ineligible to apply because this would represent a conflict of interest.

It is not known how many local agencies are capable of handling the demands required by such a large project. CCM members estimate that it will be June or July before the final selection of a Principal Recipient can be completed. After this occurs, the Global Fund Secretariat must again review and accept the Principal Recipient in order for disbursement of funds to occur. However, if UNDP were to have been the Principal Recipient, disbursement could have begun as early as late February or early March, and ARV scale-up could begin immediately. Prevention programmes targeting thousands of people including traditionally under-funded high-risk groups such as men who have sex with men and sex workers, will also be delayed as a result of the Global Fund's decision.

In neighbouring Honduras, UNDP is the Principal Recipient and the Global Fund project has been implemented rapidly and over 1,500 people are now receiving ARVs. However, in 2002, after the Honduras project had already begun functioning, the Global Fund Board changed its guidelines and stated that UN Agencies would no longer be acceptable as Principal Recipients, because the Fund wants to build local infrastructure within countries and not rely on the UN. However, as one member of the Guatemalan CCM stated, 'We know that UNDP has the infrastructure and ability to be the Principal Recipient at this moment, and the Global Fund has told us that we are supposed to be the decision makers about our own project. But they won't even let us decide who will be the Principal Recipient.'

Yolanda, a widow living in Guatemala City who is now in the advanced stages of AIDS, and has four children, commented that 'I don't know what the Global Fund is. I was told last year that that there would be hope that I could receive treatment very soon. That was in September. Now I am too sick to care for my children and I have sent them to a cousin. If I die soon, it will be a blessing because I am tired of being sick.'

(An update from conversations held with the Guatemala Portfolio manager on 10 March 2004 indicates that the Public Tender process will begin soon in Guatemala and is expected to take three months, meaning that from the project's acceptance in October of 2003, it will take approximately seven months to just choose the Principal Recipient.)

— *Richard Stern*

Nicaragua: Delays in purchasing ARVs for Global Fund project

On more than one occasion we have insisted that the bureaucratic procedures implemented by CCMs or by the Global Fund itself, must yield to quicker mechanisms that would enable access to antiretroviral medicines in as little time as possible.

However, in Nicaragua the purchase of antiretrovirals financed by the Global Fund is an extremely slow procedure, which results directly in the increase in the number of people who continue to die because they are not provided with medicines in a timely manner due to negligence and bureaucracy.

The Global Fund Project in Nicaragua was approved in January 2003. At that time, PLWAs were injected with new hope as they could now finally visualise a future in the horizon. Sadly, many have already died without ever receiving the long-awaited medicines.

What happens to financing offered by the Global Fund to save lives?

Over the course of a number of telephone conversations with NICASALUD, the Principal Recipient in Nicaragua for Global Fund financing, we have discovered that the disbursement for the purchase of antiretroviral medicines has not yet been made, although the contract was signed almost six months ago. (Nicaragua has already received some money from the Global Fund which was assigned to Malaria programmes, but none has been disbursed for the purchase of antiretrovirals.)

The Global Fund headquarters in Geneva confirmed that the funds for the antiretrovirals had not been sent. They informed us (in February) that they had received the report from Nicaragua, and that after it was verified (which would take approximately a week) the funds would be sent.

Another situation that will delay even further the delivery of the medicines, is that according to NICASALUD, the organisation identified as the possible distributor (IDA), would initiate the purchase procedure only after the contracts are signed and they receive a 50% advance of the total costs. In addition, the purchase procedure takes between 8 and 16 weeks for ARVs to be delivered to the country (some medicines take 8 weeks to be delivered, others 12 and some up to 16).

Due to the above, if the Global Fund, the National AIDS. Programme, NICASALUD, the agency purchasing the medicines and any other institution involved follow the 'normal' procedure, the ARVs would not be available for PLWAs until June or July at the earliest.

How many PLWAs have died in Nicaragua since 1996 when antiretrovirals were made available to the general public in other countries? How many PLWAs have died since the AIDS Legislation (Law #238) was approved guaranteeing the right to treatment in 1996? How many more have died since January 2003 when the Global Fund project for the country was signed? How many more have died since the contract was signed? How many more PLWAs will die in Nicaragua before the medicines are purchased? How many more before the medicines are effectively distributed to the hospitals in that country? Must we continue to count unnecessary deaths?

We hope these words do not prompt a list of excuses as to why the purchase and delivery of these medicines has been delayed. We are not interested in excuses, what we are interested in is sensitising those who have the lives of these peoples in their hands so that they understand the value of each human being and expedite these procedures as if it were for the benefit of their own family. We hope that bureaucratic procedures do not continue to result in totally needless deaths.

— *Richard Stern* and *Guillermo Murillo*

Women most affected by HIV/AIDS

As the numbers have shown, women bear the brunt of the HIV/AIDS disease especially in the Third World. The following article by the *WOMEN'S GLOBAL NETWORK FOR REPRODUCTIVE RIGHTS (WGNRR)* explains why HIV/AIDS is a gendered disease.

At the beginning of the AIDS epidemic, researchers and public opinion held that only special groups, like drug users, homosexual men, and prostitutes, were at risk. The perception was that if they would only change their behaviour, the transmission of the virus could be stopped. However, the way the epidemic has spread shows a different picture: 'We have seen HIV and AIDS flourish in the poorest, least educated and least white populations, as well as among women.'

Nowadays, the concept of vulnerability is applied for a better understanding of the AIDS issue. Vulnerability means that marginalised groups within a population, whether socially, economically, politically or culturally, face a higher risk of HIV infection. Those who are vulnerable are hardly in any position to choose or act on their own free will. 'When poor women have to choose between an immediate economic crisis at home and the possibility of a disease they barely understand, the decision is easy.' To lower the risk of infection for the vulnerable groups, far-reaching changes at the economic, social and cultural levels need to be made.

Women, who belong to the part of the population that is most vulnerable and most affected, receive the least attention from the medical sciences, healthcare providers, policy makers, and the public in general. *AIDS is a gendered disease.*

Biologically, women face a higher risk of HIV infection. During heterosexual vaginal intercourse, the seminal fluid of infected men comes into contact with the mucous membrane of women's sexual organs. Sexual practices like anal intercourse and dry sex increase the risk of transmission of the AIDS virus because of the greater chance of lacerations. Women who want to conceive face a dilemma: unprotected intercourse exposes them to HIV infection.

Economically, women are subjected to a higher risk of being infected with HIV. The majority of women around the world are poor. In many instances they are dependent on their partner's income to sustain themselves and their children. A woman whose husband is unfaithful is virtually powerless to protect herself if her husband refuses to wear condoms. In other cases of economic necessity, some women find work as prostitutes. Some families even sell their children to the pornographic or sex industry. As sex workers, women (and children) are rarely in a position to negotiate for safe sex. They are often victims of rape and sexual assault. The poor economic position of women and girls also restricts their access to adequate health care and treatment once they are infected with HIV.

The *social and cultural status* of women also puts them at a higher risk of becoming infected with HIV. Whereas a man can freely decide to protect himself and his sexual partner from infection by using a condom, a heterosexual woman does not have this choice. She is dependent on the co-operation of her male partner. Since many women around the world are still subordinate to men, their ability to prevent infection by HIV is very limited. Women are often trapped between their wish to show love and trust to their partners, their wish to become mothers, and the necessity to protect themselves.

Women are exposed to a lot of violence. Daily, thousands of incidences of rape occur the world over, more often than not involving family members. There has been little legislative and cultural

JAMUNA's story — India

Jamuna is 19 and seven months pregnant with her first child. She is also HIV+. Three years ago she was married to Nagu, a quarry laborer who works in the neighbouring state of Andhra Pradesh. Nagu's work often took him away from home for weeks at a time. He would visit home occasionally and give his earnings to his mother and wife. After Jamuna became pregnant, her in-laws sent her to stay with her parents in Tamil Nadu, as is the custom. Two months ago Jamuna went to the hospital, complaining of fever and diarrhoea.

'After examining me the doctor said I would have a blood test to find out if I had HIV infection. After the first test showed I was positive, he sent it to another hospital and they confirmed the result. The doctor told me it would be best for my husband to have his blood tested too, so my father went to Andhra and spoke to my in-laws about it. They think I have been punished with this disease because I must have been unfaithful to my husband.

But Nagu himself told me that he and his friends slept with the women in the quarry. He said that at the end of the day it was normal to buy some liquor and have sex, to relax the body.

My father tried his best to get Nagu to see a doctor, but he refused. I haven't seen Nagu since. My parents got me admitted into hospital because I feel sick often. We've heard that my in-laws have decided to find another match for Nagu. At first I thought I would somehow try to stop them from getting him married again, but I just don't have the energy. If I can keep enough strength to go through my pregnancy, all I'll have is my child. I pray that at least my child will be free of this disease.'

Powerless to Negotiate Safe Sex

'In most societies of sub-Saharan Africa, penetrative heterosexual intercourse without protection is the primary cause of the spread of HIV. Such unprotected sex accounts for about 90% of HIV infections among African women and their male partners. (...) About 20-40% of women in developing countries are exposed to the risk of HIV/AIDS, as well as pregnancy, due to rape. Rape, therefore is a significant gender issue in HIV/AIDS infection for women.

progress in recognising the right of married women to refuse sex. All too often in war, rape is a powerful weapon used by the aggressor, and it routinely occurs during ethnic conflicts. Then there is also the well-known and regular brutality on the part of the military and police force in many parts of the world.

Poor health care

Women, especially HIV-infected women, receive *less quality health care* and medical attention.

HIV infection in women is poorly researched and poorly understood. It has been shown that women, after having been diagnosed, succumb to the disease sooner than men. This may be due to the fact that they are diagnosed late, have less access to treatment, and put their own health last, caring for family members and relatives first. In addition, little attention has been paid to the fact that women display symptoms of HIV infection which are different from men. Medical research has focused mostly on men, reflecting the well-known patriarchal bias that adversely affects other areas of women's lives.

Poor women are especially dependent on public healthcare systems, whose quality has been continuously deteriorating in many parts of the world. In many countries, government hospitals and healthcare institutions are a source of infection when they unwittingly use infected blood during transfusions or when unsterile needles are used. Women who suffer from anaemia and haemorrhaging during pregnancy and childbirth are more at risk because these are instances that would require blood transfusions.

HIV-positive women in particular face a wide range of barriers to adequate health care. WGNRR carried out extensive research of the literature and studies on HIV-positive women's access to health care. Their research revealed that the current position of HIV-positive women vis-à-vis healthcare services is intricately linked with historic and current institutionalised racism and sexism, past and persistent HIV-related discrimination, coercive practices, and breaches of privacy/confidentiality.

The greater burden of coping with the disease falls on women, within the family and wider community. In addition to being caregivers of the sick and dying as well as of children of the deceased, they also have to provide economically for their families.

HIV-infected women and men are

Sexism in Research

'Since the start of AIDS, [US] federal agencies have blocked the inclusion of women in meaningful studies, largely because of institutionalised sexism. (...) Much research is overly focused on our reproductive organs, such as searching for HIV reservoirs in the vagina. (...) Another problem is the severe under-enrolment of women in HIV clinical trials. This hinders the collection of meaningful data about possible gender differences in drug function.'

exposed to stigmatisation within the family, community, public, and health systems. Most people are not only afraid of the infected persons but they also reject and blame them for their condition. The bodies of infected persons are regarded as a source of evil. Women can pay a high price if their infection becomes public, and risk being expelled from their homes and separated from their children, desertion by their husband or losing their jobs. Misinformation and myths about how the infection spreads, economic discrimination and social stigmatisation make the lives of many infected sufferers unbearable.

AIDS flourishes in unequal social and economic structures *within* a society as well as *between* societies, and it reinforces these structures.

The higher occurrence of AIDS among the marginalised and socio-economically vulnerable is not only due to the unequal structures within a given society. It is also connected

Discriminated Against – A Honduras Story

A 42-year-old woman with five children who has been a widow for a year says: 'I only worked in houses washing clothes. When the people found out that I had HIV, they asked me to stop working for them. They took away the house we were renting, and the people asked me to use gloves while I washed other people's clothes. We were desperate and we didn't have anywhere to go. Everything collapsed. My husband's family took my youngest daughter away from me. They never accepted that he died of AIDS and that my daughter has it too. It's sad. Sometimes I want to talk about it and express my feelings, but I can't because I'm afraid I will be rejected. When I used to visit my family, they gave me water from broken glass. They told my children not to hug or touch me. I don't go to see them anymore. I don't like to break my heart. Only my son needs me. When I had a bout of herpes, they said they were taking me to the hospital to die and that when I died, they weren't going to bring me home for the wake. I've suffered the contempt of my family. That hurts, but I keep going. It's not the disease that kills; it's what people say. Nobody knows what I carry inside. I don't like it when they call me sidática [woman with AIDS].'

to global economic development and the restrictions and conditions imposed by IMF and the World Bank on many governments. Through structural adjustment programmes, public healthcare systems have deteriorated, and the privatisation of services has been promoted.

The economic situation of millions of people has worsened, and once again women face the brunt of the economic crises. Unemployment rates have risen among the marginalised, forcing women and men to migrate, work in precarious jobs, including prostitution, or live in dire poverty. Different medicines are available to slow down the course of AIDS and prolong the life of the affected. However, the prices charged by the pharmaceutical companies are so

Resources in an Unequal World

While 90% of the US$7.6 billion spent worldwide on AIDS prevention, medical treatment and research since 1992 was concentrated in industrialised countries, only 10% of those resources were destined for the developing countries, although they represent 75% of the world population. The problem, then, originates in the inequitable distribution of wealth, power and autonomy. The greater these differences, the more fragmented societies are, and the faster HIV spreads.

high that the vast majority cannot afford medicines for AIDS treatment, nor can governments of poorer countries subsidise them. Apart from the medicines, adequate health care is required for those infected – care which the resource-strapped public health systems are unable to provide.

AIDS has thus many dimensions. It cannot be viewed as a medical problem only. It deeply affects people, families, communities, and societies. It is closely intertwined with the relationships between men, women and children, within and between families. AIDS is intricately connected with economic marginalisation, cultural practices, social injustice, discrimination, and poverty.

WGNRR is an autonomous network of groups and individuals. It has links in some 157 countries in all continents and coordinates the Network from Amsterdam. *<WGNRR@wgnrr.nl>*

Time to break the silence – a campaign

World Health Report

Going public about HIV: A South African story

An HIV-positive South African tells her story. Faghmeda was diagnosed in 1995 and disclosed her infection in 1996. In her words, 'Coming back home after the doctor told me that I was HIV-positive, I asked myself what I was going to do. Could I tell my people because I know that in the Muslim community it's a big sin to have AIDS, so what was I going to do. I told one of my friends and he also told me not to tell my family unless I was prepared for it.' Faghmeda went public on an Islamic radio station and says every time someone criticises her for doing so, she always reminds them that by not going public she is endangering the lives of others in the community.

WGNRR issues a 'Call For Action' every year on 28 May – 'The International Day of Action for Women's Health' – when women's groups the world over carry out a range of activities highlighting the problems related to healthcare for women and calling for improvements. Some proposals for action in the Call against HIV/AIDS are outlined below.

Inherent strength, gained through generations of struggle for justice and the support of the women's movement, has enabled many infected women to come out in the open, declare their status and face their community. They have the courage to challenge the situations that caused their infection. They have come together to demand better treatment and access to quality care and refuse to accept the seemingly inevitable.

Around the world, there are many women who form self-help groups, action groups, and organise campaigns. They care for each other, inform each other, and educate their fellow women about AIDS. They dare to challenge their socially, economically, and culturally subordinate positions, and demand the recognition of women's rights as human rights. They know that women must actively assert themselves, confront reality, and avoid infection in themselves and others.

As AIDS is not only a medical problem, but also an expression of the social injustices within and between societies, measures should address all interconnected social levels. Prevention of the disease cannot be isolated from efforts to improve the status of women, or investments in healthcare systems. Negotiating the use of condoms cannot be viewed separately from negotiating sexual rights. Demanding adequate health care for infected women must include demands for comprehensive health care for all.

It is of utmost importance that the described complexity of AIDS and the special situation of vulnerable groups are recognised and acknowledged at all levels and segments of society: families, communities, provinces, states, religious and professional communities, healthcare systems and employers. Denial of the seriousness and magnitude of HIV infection and AIDS, especially at the national level, endangers the lives of many and threatens the future of the country and its people.

Action proposals – What you can do

National Level:

♦ Work to end discrimination and stigmatisation of HIV-infected children and adults. Demand adequate social support services and counselling for people living with HIV/AIDS and their families.

♦ Assert women's, including HIV-positive women's, sexual and reproductive rights. Sexual rights are, for example, the right to freedom, which excludes all forms of sexual coercion, exploitation and

The courage to speak: A story from Namibia

Emma was the first person in Namibia to come out publicly as a woman living with HIV/AIDS. She relates the reason for making her HIV status public in spite of all the stigma.

'I did it because of my three sisters. When I first found out about being infected with the AIDS virus I just wanted to commit suicide. But then I thought about my three younger sisters and I wanted to save them from the same fate. I wanted to warn them that it could happen to them like it happened to me. (...) I wanted to do something good. I wanted people to know what it is like to be HIV-positive. I wanted to tell the world that even after you have been diagnosed positive you are not dead, you are still very much alive and still have a lot of living to do. You may even have been living with the virus for years already without knowing it. I also wanted to warn future girlfriends of the man who infected me without saying his name in public.'

HIV is not a death sentence – says Chilean couple

HIV has changed the lives of 36-year-old Angela and 38-year-old Benjamin, but not all of the changes have been tragic. Although she is positive and he is not, this Chilean couple assert that the situation has brought them closer together and made them more committed to others through their work fighting for the rights of people living with the virus.

How did your lives change after the diagnosis? 'Of course, my entire life changed with HIV. But as they say: 'After the rain a little sun must shine.' Each step brought us closer together as a couple and as human beings. Now I enjoy things in detail, with the laughter of my daughter. Before it was all materialism, just work. It has also to do with the fact that we have really committed ourselves to working with support groups. This is something that I don't get tired of saying to positive women: do other things, get in touch with people, and come together. If I had stayed at home, hidden away, today I wouldn't have medicine, and neither would my daughter. I would have aged 20 years, and maybe I wouldn't even have Benjamin by my side. Even though I get tired sometimes.... Is it all worth it? Despite everything, I think it is. Because when I help another person get medicines, I feel really great, very satisfied. Benjamin and I have learned that, in a way, HIV is just a word, nothing more.... If I have my drugs and I take them like I am supposed to, I can live many years.'

Uganda leads the way in prevention

Uganda has been one of the first countries in Africa to recognise AIDS as a public health problem. Since 1992, it has successfully employed a range of programmes to prevent the spread of AIDS.

'Through STD/AIDS Control Programmes, strategies that increase people's awareness and knowledge of HIV/AIDS have led to a positive sexual behaviour change. The practice of abstinence before marriage, faithfulness during marriage and condom use, especially during sex with non-regular partners, have been promoted. In addition, efforts to enhance capacity building to deal with the HIV/AIDS epidemic continue at both the national and community levels. Health personnel has been sensitised and trained to deal with the epidemic, and attempts have been made to equip health centres and other facilities. In terms of care, counselling and at times material assistance have been availed to people with HIV/AIDS so as to reduce the personal and community impact of HIV/AIDS. Furthermore, epidemiological surveillance of HIV infection and AIDS cases have been and continue to be carried out in order to monitor the magnitude and trends in the epidemic.'

abuse. Further it is the right to autonomy, integrity and safety of the body, which includes control and enjoyment of our own bodies free from torture, mutilation, and violence of any sort.

- Work to overcome harmful traditional practices and harmful cultural definitions of masculinity and femininity.
- Address social problems that are connected with AIDS such as poverty, the child sex trade, and violence against women.
- Demand social and legal changes that empower women economically, and that safeguard their human rights.
- Hold your government responsible for good quality healthcare services, especially sterile needles in hospitals and other health centres, safe blood for transfusion and free access to female and male condoms. Demand that everyone, not only the rich, has access to medicines that can slow down the disease.
- Demand from your government the allocation of resources for HIV/AIDS education, prevention, and support of infected persons and their families. Hold your government accountable for funds received from international institutions for these activities.
- Demand gender sensitisation programmes for planners and healthcare providers who often have limited information or are misinformed about treating women with HIV.
- Build alliances with other NGOs and community groups, progressive parliamentarians, legal counsellors, and journalists.

International Level:

- Join forces with groups and organisations that campaign globally for social justice, economic equity and recognition of women's human rights.
- Support international campaigns to ensure human rights, women's reproductive and sexual rights, and the rights of patients to optimal treatment and confidentiality.

Statement of concern about women and AIDS/HIV

13th International AIDS Conference, July 2000

'While governments ask women to bear the heavy social burden of nursing the sick and dying, we ask governments to support policy and decisions which include the gender interests and concerns of women and men. Building responsibility for HIV/AIDS is not a private concern but a political and social concern, and must draw together all our collective strength. (...) The imperative to treat HIV/AIDS as a collective social responsibility requires action and decisions from the whole of society and government to bring the pandemic under control and to ensure the survival and longevity of all women, men and children. By promoting a culture of rights and gender equality, responsibility and choice in relation to HIV/AIDS we believe we can end women's overwhelming, biological, social and economic susceptibility to HIV and affirm the right of all people to life and dignity.'

♦ Join campaigns to encourage states to regulate drug prices and enable compulsory licensing of AIDS drugs in their countries. Support the international demand made to transnational pharmaceutical companies that AIDS medication should be sold at low prices.

♦ Lobby government officials in your own country to support international efforts to fight against the further spread of the AIDS epidemic. Remember, most governments are represented and have a say in organisations such as UNAIDS, the World Health Organisation and the World Trade Organisation.

♦ Share successful strategies, actions, regulations, approaches implemented in your country with women's groups, organisations and networks in other countries. Do not let this information be lost.

Violence against women fuels HIV/AIDS

Shereen Usdin

Women in South Africa are brutalised both inside and outside their homes. This violence, combined with poverty, the right to control women, female discrimination and women's vulnerability to HIV/AIDS, is driving the epidemic.

During South Africa's transition to democracy the world watched in awe as apartheid crumbled and a nation with a soul emerged. Archbishop Desmond Tutu — in a burst of post-apartheid euphoria — described South Africa as the 'Rainbow nation'. For a moment it felt like that's exactly what we were.

Now, a decade later, as the dust settles the country has become famous for other things. As well as being at the centre of the global AIDS epidemic (one in ten South Africans is HIV-positive) we have the dubious honour of being the rape capital of the world. It is becoming clear that violence against women is fuelling the epidemic.

Take Joyce Malope, a 30-year-old Johannesburg activist infected with the virus after a brutal encounter.

'I was walking home from work when he drove up to me. He was dressed as a priest, soft-spoken and sweet. There was even a bible on the seat of his car. I said: "Father, how can I help you?" He asked directions to a church. It was close to my place. I thought to myself, why shouldn't I help this priest, only to find later, he was going to be my rapist...

'En route, another guy jumped inside. He pulled out a gun and said: "If you scream I'm going to kill you." They put a plastic bag over my head. All I could see was lights. He put the gun into my mouth. At the time, I didn't think of HIV, I just thought, "as long as you don't kill me..."

'After, they dropped me on the pavement near my place. No-one stopped to help. I heard people say, "Maybe she was beaten up by her husband. Probably he found her sleeping with someone else." Like that justified everything. Finally a man stopped and took me to hospital. My first HIV test was negative. I was told to come back after the "window period" (the period during which one is infected but the virus is not yet detectable in the blood). It was then that I found out I was positive.'

With the high rate of HIV infection in South Africa, the odds of Joyce becoming infected were high. The violent nature of rape increases this risk.

But more women are infected by their husbands or boyfriends, where violence or fear of it determines how and when sex occurs. Despite a constitution which enshrines a woman's right to live 'free of violence in both public and private spheres', the home is probably the most unsafe place for women in South Africa.

According to UNAIDS, up to 80% of HIV-positive women in long-term relationships acquired the virus from their partners. This in a society where men having multiple sex partners is the accepted norm. Ironically, marriage is one of the greatest risk factors for women today.

Neither gender violence nor AIDS are unique to Africa. But for women the combination of gender violence, patriarchy, poverty, female biological vulnerability, and a virulent strain of the HIV virus makes for a lethal cocktail. In sub-Saharan Africa, an estimated 12.2 million women carry the virus compared with 10.1 million men.

According to a recent UN Development Fund report: 'There is now a fast-growing understanding

Joyce Malope with her three children in Johannesburg: 'He put his gun into my mouth. I didn't think of HIV. I just thought "as long as you don't kill me."'

that gender inequality heightens women's vulnerability to the epidemic and leaves them with untenable burdens when HIV/AIDS enters households and communities.'

In Africa the problem is rooted in a patriarchal society. According to Karen Dzumbira of Women in Law and Development in Africa (WLDAF), cultural systems give men rights over women and violence is commonly condoned as a way of maintaining control. This ranges from female genital cutting, wife inheritance (where a woman must marry her late husband's brother), polygamy and bride price (in southern Africa called *lobola*). 'The lobola system reinforces the idea that a woman is a man's property and he can do with her what he wishes,' says Karen Dzumbira.

Most women are in no position to bargain. It is almost impossible to negotiate any form of protection with a partner who believes that it is his right to expect his partner's obedience.

Joyce Malope was also raped by her husband: 'He was often forcing himself on me. There was nothing I could do. It is not easy in our culture to protect yourself from your husband - because he can use violence on you.

'Men take you as a slut if you ask them to wear a condom. They accuse you of sleeping around or they say: "You don't trust me." Some will just beat you up. When it comes to using a condom, men complain they won't "eat a sweet with its wrapper on".'

It's also widely believed that vaginal lubrication signifies infidelity. To avoid violent punishment many women insert herbs and other substances inside their vaginas to 'dry up'. Dry sex makes abrasions and trauma more likely and increases the risk of HIV transmission.

Many women are financially dependent on men and are trapped in abusive relationships that expose them to HIV. The way Joyce describes it: 'You have to listen - your choice is to stay and get beaten or he leaves. To survive, you end up protecting the very person who is killing you.'

And it is perpetuated through generations. 'Boys see their fathers doing it, so they take it as normal. Even our mums will say: "If he beats you, try to change your attitude."'

Violence against women fuels the epidemic and the epidemic fuels violence against women. Ironically, because many women discover their status when pregnant, they are the ones accused of 'bringing AIDS home'. Violence is a common consequence.

Empower women

Male violence and discrimination against women are central to HIV transmission. Widespread machismo means women have little control over sexual relations facilitating the spread of the virus.

As a result most women will not disclose their status. In a recent study in Tanzania, fear of violence and abandonment was cited as the main reason women had not told their partners that they were positive. Nearly 39% said they had been physically abused by a partner and 17 % had been sexually abused.

For 24-year-old Thembane from Soweto the consequences were bleak: 'When I told my husband he said: "You are lying." He beat me in my face because of the HIV thing. He didn't want me to say anything to him or anyone else.' Thembane's husband refused to go for a test and eventually left her.

Fear also prevents women from seeking counselling or treatment. Disclosing one's status is often perceived as 'bringing shame' on families and communities. So many women remain silent and don't seek the help they need to stay healthy. A much-publicised story was that of Gugu Dlamini - a young woman in Durban who was murdered by her neighbours after she publicly disclosed her status.

Africa has responded to the crisis in varying ways, some practical, others potentially damaging. An example of the latter has been the revival of 'virginity testing', where young girls' genitalia are inspected at public ceremonies and certificates given to those who make the grade. In Swaziland, women protested the re-introduction of *umchwasho* - where young girls wear woollen tassels in public to signify their virginity and commitment to abstinence. Some projects look to revive positive cultural practices such as non-penetrative forms of sexual release promoted amongst youth in the past.

Obviously a vaccine will protect women but that is a long way off. One of the more sensible ideas being explored is the development of vaginally inserted microbiocides — which will kill the virus and can be administered without a partner's knowledge. Similarly, the female condom. Activists are also pushing for rape survivors to have legislated access to antiretroviral treatment.

However, these solutions don't address the root of the problem - gender inequality. That's why programmes focusing on the empowerment of women, human-rights education and raising self-esteem are growing throughout the continent. Empilisweni Centre, for example, was established as an AIDS and health-education project in an impoverished rural area of the Eastern Cape. Founded by Elizabeth Musaba, the project focuses on decreasing women's economic dependence on men - as well as highlighting the link between sexual violence and AIDS.

But what about the men? The jury is still out on the effectiveness of counselling abusive men. More projects are engaging men to shift social norms. But many gender

activists complain that programmes focusing on men take away scarce resources that should be for women. Musaba, whose project involves men, says this misses the point: 'In Zambia in the 1980s we got nowhere with our family-planning programme until we began to incorporate men. We will get nowhere with AIDS if we exclude them. We mustn't lose sight of the ultimate goal, which is to build the capacity of women, but we can only succeed if the two are done simultaneously.'

Alice Munyua of FEMNET, a broad network of African organisations advocating women's rights, agrees: 'We believe we have to bring men on board because they hold the power and authority.' The network is facilitating a process of 'Men Against Gender Based Violence' which involves projects in Namibia, Malawi, Kenya and South Africa.

McDonald Chapalapata of the Malawi project believes this work is already bearing fruit. 'Our project brings on board influential men from the judiciary, police, politicians and churches to speak out publicly against gender violence. We have pastors who are preaching respect for women's rights. We run workshops on gender equality and help form village committees which focus on women's rights and the law.

'We are definitely starting to see results. In the southern lakeshore district of Malawi, the village committee arrested a police officer who beat up his wife after she tried to leave him. It took great courage to arrest a policeman.'

Violence against women and the AIDS epidemic sit together like a bad marriage. While the merits of individual counselling may be debated, the tide of both epidemics will not turn unless we counsel society as a whole.— *The New Internationalist*

Shereen Usdin is a doctor and health-communication specialist. She helped found the Soul City Institute for Health and Development Communication in South Africa.

The feminisation of the AIDS crisis

Rachel Evans

United Nations and US think-tank documents on the 'feminisation' of the AIDS disaster give the impression that these expert panels and their finely worded 10-point action plans are assessing a disaster afflicting another planet or species.

Their horrific statistics are believable and their wish-lists of solutions look and sound reasonable. But their practice shows that the corporate elite they speak for has no interest in solving this crisis.

Women's HIV infection rates are on the rise. According to *Fatal Vulnerabilities - Reducing the Acute Risk of HIV/AIDS among Women and Girls* (a February 2003 report from the Washington-based Center for Strategic and International Studies), in 1997, 41% of those infected with the virus were women. By 2002, women comprised 50% of the 40 million people infected with HIV.

Third World women are bearing the brunt of the increase. Without access to life-saving drugs - available in most First World countries - those infected can expect to die within three to five years. Stephen Lewis, the UN's special envoy on HIV/AIDS in Africa, told the Microbiocides 2004 conference in London that African women's rate of infection stands at 58%, rising to 67% for women between the ages of 15 and 24.

According to Lewis, in urban Botswana women aged 15 to 19 have infection rates of 15.4%. Men of the same age have an infection rate of only 1.2%. For women between the ages of 25 and 29, the infection rate is a horrific 54.1%, while it is 29.7% for men of the equivalent age.

According to *Fatal Vulnerabilities*, in parts of the Caribbean, girls are infected at twice the rate of boys.

Poverty, sexism, rape and war are behind the dramatic increase. In conflict situations, such as in Sierra Leone, the Democratic Republic of Congo and Rwanda, sexual violence has been used as a weapon of war, exposing large numbers of women and girls to HIV. Refugee, orphaned and internally displaced women are particularly at risk of HIV infection through rape.

Fatal Vulnerabilities notes the growth of the phenomenon of 'sugar daddies' across sub-Saharan Africa, where richer, older men seek young girls as wives and mistresses, presuming them to be HIV-free.

HIV infection is dramatically more prevalent among prostitutes than the rest of the population. UNAIDS, the United Nations programme on AIDS, estimates that as many as 50% of sex workers in Kenya are HIV-positive, while 45% are in Guyana, and 50% are in Burma.

Lack of sex education is a killer. In Cambodia and Vietnam, almost 50% of women between the ages 15 and 24 who have been surveyed believed they could contract HIV from a mosquito bite and nearly 35% believed a healthy-looking person could not be carrying the virus.

The pandemic is generating orphans — there are 13-15 million people under the age of 15 who have lost one or both parents as a result of AIDS. By 2010 the number is expected to rise to 25 million. Millions of children, mostly girls, are pulled out of school to look after sick relatives, do back-breaking paid work and run households.

An international outcry and a massive flow of money to stop the spread of the deadly virus has not been forthcoming.

Lewis pointed out that a UN task force on the plight of women in South Africa was only set up in 2003.

He highlighted the failure of a specific women's programme available in 2000 in some fortunate African villages — pregnant women were given a course of Nepravine, a drug that halted the transmission of HIV from mother to daughter.

Antiretroviral drugs which stem the onset of AIDS, available in the rich countries, were not available to African mothers due to exorbitant prices set by pharmaceutical companies.

The programme was obviously short-sighted, but better than the South African government's response, which was to withdraw the provision of these drugs. Parks Mankahlana from the governing African National Congress commented in *Science* magazine: 'The mother is going to die and that HIV-negative child will be an orphan. That child must be brought up. Who is going to bring the child up? It's the state, the state. That's resources, you see.'

Ten-point plans and conferences of elite experts have not resulted in solutions to this crisis. What's needed is massive public funding for health care, the flooding of infected communities with generic AIDS drugs, intensive sex education campaigns and the strengthening of women's organisations that fight sexism, rape and war. — *Green Left Weekly*

Alternative AIDS therapy from cheap generics

Even as millions of dollars and scientific resources are pumped into the search for an HIV/AIDS vaccine, over the last 15 years, no vaccine has appeared on the horizon.

AIDS vaccines currently tested on people are said to be both ineffective and harmful. When vaccine trials are conducted in the Third World, where healthcare systems and infrastructure are weak, and inadequate laws make it impossible to monitor the use of these drugs on unsuspecting populations, issues of ethics, accountability and transparency are a major concern. The problems related to HIV/AIDS drugs like toxicity, adverse effects, resistance, unaffordable costs and dependence on foreign resources, clearly show that safe, inexpensive alternative self-reliant therapies have to be sought.

The following articles by scientists at the Institute of Science in Society, UK, report on recent developments in alternative AIDS therapies.

Dr Mae-Wan Ho is Co-Founder and Director of the Institute of Science in Society, UK (*www.i-sis.org.uk*).

Sam Burcher is a Researcher with the Institute of Science in Society, UK.

Conventional combination treatments for HIV/AIDS cost $22,000 per patient per year in the US. Do cheaper and less toxic drugs exist? *SAM BURCHER* and *DR MAE-WAN HO* report.

A quintet of older drugs could make a cheap and safe alternative to current anti-HIV drug cocktails, claim Drs Aldar Bourinbaiar and Vichai Jirathitikal of Immunitor Corporation in Thailand, which created the V1 AIDS vaccine (see article '"Pink Panacea", at last a vaccine against AIDS?').

In a paper published in *Current Pharmaceutical Design* in 2003, the two scientists review evidence suggesting that these old, widely available conventional drugs may have anti-retroviral and immune modulating properties, which could help recover the immune system of HIV/AIDS patients.

Warfarin

Warfarin is a synthetic drug derived from the naturally occurring coumarins found in a wide variety of plant species worldwide. Coumarins are the parent organic compounds that work as natural pesticides in plants such as lavender, grasses like sweet clover and food plants like strawberries and lemons. In 1868, coumarins were synthesised in the laboratory to make perfumes and flavouring. When combined with glucose they produce glycosides, which are anti-cancer, anti-fungus and anti-coagulant. All structurally related courmarins show potent anti-HIV activity. The use of coumarins as an immune support accompanying standard chemotherapy treatment has significantly improved survival rates of colon cancer patients. More recently, warfarin is used as an anti-coagulating drug in the treatment of heart disease and stroke.

There is some anecdotal evidence suggesting that a small daily dose of 2mg of warfarin does not affect the 'prothrombin-time', a lab test to monitor blood coagulation in HIV patients, but does significantly lower viral loads.

Warfarin possesses four essential properties for fighting HIV: inhibition of serine protease, aspartyl protease, reverse transcriptase and integrase, all of which are central to the virus's ability to replicate.

An average PI (protease inhibitor) used in triple-drug treatments of HIV cost between $10-$20 per day, in contrast to a daily dose of 2 mg warfarin which costs as little as 10 cents.

Reverse transcriptase (RT) inhibitors are also essential in the successful treatment of HIV/AIDS. By far the most prescribed RT is AZT, which has side effects in up to 75% of patients with HIV/AIDS.

Warfarin is of further value in the treatment of cognitive functions in HIV/AIDS patients. A daily dose of warfarin appears to improve the fluency of speech and mental aptitude of patients suffering from progressive dementia associated with the full-blown AIDS disease.

Bourinbaiar and Jirathitikal found that a combination of warfarin with anti-HIV compounds discovered by them, such as cimetidine and lavamisole, seems to enhance the beneficial immune effect.

Cimetidine

Cimetidine is an over-the-counter ant-acid or anti-ulcer drug

otherwise known as *Tagamet*, and as such inhibits gastric acid secretion via histamine type (H2) receptors on parietal cells (in the stomach.) Cimetidine was developed as part of a research effort led by Nobel laureate Sir James Black, and was the first H2-antagonist to receive approval from the FDA (Food and Drug Administration) in 1977. On account of its excellent safety record, it is now widely available as an over-the-counter drug.

Cimetidine first came to the attention of Bourinbaiar and Jirathitikal when they observed the inhibition of human T cells leukaemia virus (HTLV-1) secretion from chronically infected cells. This led them to the idea that viral release is regulated in the same way as gastric acid secretion, and to discover that cimetidine has broad anti-retroviral activity.

Further studies revealed that cimetidine, unlike AZT, which was used as a control, produced no cytotoxicity even at the highest dose tested (1mM). According to the authors, this is an exceptional drug index that cannot be matched by any drugs currently used in the treatment of HIV/AIDS. Twice daily doses of 200mg of cimetidine will suffice to provide steady IC50 levels (concentration producing 50% inhibition) for HIV replication.

It appears that the success of H2 antagonists tested for anti-viral activity depends on the imidazole nucleus. Some, though not all, non-nucleoside reverse transcriptase inhibitors (NNRTIs) possess imidazole rings. It is thus likely that cimetidine acts like an NNRTI and has the ability to treat HIV infection.

NNRTIs have a reputation for rapidly eliciting resistance due to mutations of the amino acids surrounding the NNRTIs' binding site. So emerging strains of resistant HIV can be confronted if the NNRTIs are combined with other anti-HIV agents.

The combination of warfarin and cimetidine was previously thought to be incompatible, but there have been no reports of adverse reactions at low doses of cimetidine and 2mg of warfarin in more than a hundred available references in the TOXLINE database. In fact, the incidence of anaemia caused by cimetidine is 2.3 per 100,000 as opposed to 70% in patients treated with AZT.

In trials, cimetidine significantly enhanced a variety of immune functions both *in vivo* and *in vitro* and was successful in partially restoring the immune function in 33 AIDS patients.

Cimetidine sells over the counter for 20 cents per 400mg pill, while in China bulk buying the pills may cost as little as $18 per kilo.

Levamisole

Levamisole was synthesised in the early 1960s and used primarily for the treatment of intestinal worms in animals. In the 1990s, levamisole was approved for human medicinal use to provide immune support for colon cancer patients. Bourinbaiar and colleagues, aware that it contained the same imidazole ring as cimetidine, surmised that it might also have anti-HIV activity. They found the IC50 of levamisole to be around 0.1mM, and there was no toxicity at the highest dose of 1mM. The drug was effective against several lab strains and primary isolates of HIV-1.

However, chronic daily doses of levamisole appeared to have an accumulated toxic effect, usually severe nausea and granulocytopenia (a reduction of granulocytes, a kind of white blood cells in the blood). In general, once weekly low doses of the drug are well tolerated.

Interestingly, levamisole can either enhance or suppress the immune system depending on the administered dose. Many studies have found beneficial effects of levamisole in various immune deficiency disorders. Similarly, the drug used alone, or in combination with interferon and other anti-inflammatory drugs, significantly improves the healing of eye and skin lesions caused by herpes simplex and zoster virus. Levamisole is also strikingly effective against auto-immune diseases such as rheumatoid arthritis and systemic lupus erythematosus.

Other studies, however, have found no benefit from levamisole.

Since 1985, levamisole has undergone sporadic tests with AIDS patients with conflicting results. Some trials report no effect, while others found beneficial effects.

Bourinbaiar and Jirathitikal conclude that levamisole may have both immune modulating and antiviral activities. But caution must be exercised in using this drug because 'the dosage, administration schedule, gender and many other variables seem to have a serious influence on the outcome of the therapy'.

For human use, it cost $6 per pill, but the same pill for animal use costs just 6 cents. So the cost for treating a sheep for one year is $1, but treating a human for one year would cost $1,200.

Acetaminophen

Acetaminophen was first synthesised in 1878 as an intermediary compound in the manufacture of synthetic aniline dyes. Some 15 years later, its analgesic or pain-killing property was identified. But its clinical application did not come until 1949 when a study by Nobel laureates Brodie and Axelrod was published, and by the 1960s, it was made available as an over-the-counter drug. Brand names ascribed to acetaminophen are Paracetamol, Panadol, and Tylenol etc, as a non-toxic broad-spectrum pain reliever with few or no side effects at therapeutic doses. It is thought to cause fewer side effects than aspirin, a non-common non-steroidal, anti-inflammatory (NSAID) drug.

It is not fully understood how acetaminophen works, but it is believed to inhibit prostaglandin synthesis or the actions of chemical mediators or other substances that sensitise the pain receptors to

mechanical or chemical stimulation. During a study by Bourinbaiar and Jirantikal to identify a serine protease for use in contraceptive creams, they discovered that acetaminophen displayed significant anti-HIV activity while it was used as a negative control. The antiviral effect was specific and almost 100% inhibition was observed at 1mM (150mg/ml), while IC50 was 20mg/ml, which is satisfied by the standard dosage of a 650mg pill every six hours.

Studies of acetaminophen have shown it to be non-toxic even in the highest dose of 1mM tested, and it has been used to counteract toxicity in AIDS patients treated with AZT. No further toxicity occurred in these patients, but the anti-HIV activity in acetaminophen was not studied in these cases.

It is not yet clear how acetaminophen affects HIV replication, but it is thought to behave in a similar way to reverse transcriptase inhibitors (RT) that inhibit the synthesis of DNA from RNA.

As far as cost is concerned, these familiar painkillers may well turn out to be the cheapest of all currently available reverse transcriptase (RT) drugs.

Gramicidin

Gramicidin D was the first ever clinically identified antibiotic, predating penicillin by one year. It was isolated from the soil bacterium *Bacillis brevis* by Rene Dubois, hence 'D', in 1939. Gramicidins are short peptides of 15 alternating L- and D- amino acids that are synthesised outside the genetic coding route. The D-amino acids are unnatural in that they do not occur in proteins encoded in the genome of organisms. There are several kinds of gramicidins, differing in the amino acid sequence. They usually exist as molecular complexes of two peptides. These linear gramicidins are related to the cyclic (ring-shaped) gramicidin S discovered later in the former Soviet Union.

Gramicidin acts by causing potassium to flow out from the target cell, thus killing it. And because of its unique construction it has never been implicated in the emergence of resistant bacteria like so many younger antibiotics.

It was first used in the USA for the treatment of gram-positive infections and was also widely used in over-the-counter throat lozenges, dentifrices and mouthwashes. Nowadays, it is available by prescriptions only as a treatment for skin and eye infections. In Russia Gramicidin S is available over the counter as a prophylactic spermicide, which can be used in combination with condoms and diaphragms. It can be applied topically as an anti-microbial to treat skin infections caused by other viral or fungal sexually transmitted diseases and also burns.

Gramicidin has been in clinical use for over 60 years and it is non-toxic when administered topically or orally. However, some medical opinions suggest toxicity in systemic use. This may have been because gramicidin was used in combination with other drugs, which caused side effects. More recent studies have shown that systemic doses of gramicidin are well tolerated and efficacious in the treatment of experimental malaria in mice. Gramicidin injections cleared the malaria parasite in mice in four days. It is hoped that gramicidin can be a potent treatment for both AIDS and malaria, particularly in Africa where both diseases are endemic.

Due to the presence of unnatural D-amino acids, gramicidin has a remarkable resistance to peptide cleaving proteases found in the body, such as blood, pus, urine and saliva. It has a broad PH range (acid to alkaline) and remains active for ten years at room temperature.

Bourinbaiar and Jirathitikal have shown that gramicidin is highly effective against HIV and herpes simplex viruses at non-toxic nanogram doses. The IC50 of gramicidin against three herpes simplex isolates was 0.3mg/ml. At an even lower dose of 10ng/ml, it was active against both lab strains of HIV and clinical isolates. When gramicidin was compared with the most popular anti-HIV spermicide 'N9', it was found to be 1,000 times more effective. 'N9' could only display anti-viral activity in doses that were toxic to cells. Despite N9's equivalence to household bleach, a toxic substance not normally topically applied to skin, it continues to be evaluated as a spermicide in clinical trials.

Thus, gramicidin may be a safe and more efficient microbicide and spermicide than N9. Its use as a vaginal suppository would make an extremely cheap and efficient prophylactic or 'barrier method' against HIV and other STDs. A supply of 3kg would be sufficient for one year's use, and the cost is negligible. Gramicidin D already has US FDA approval for topical use, and cyclic gramicidin S has been used in Russia as a spermicidal preparation.

Gramicidin possesses a formidable list of attractive properties, all of which are relevant against emerging diseases. It is anti-STD, anti-fungal, anti-protozoan (malaria) and is poorly absorbed by the skin, reducing the risk of irritation. It enhances skin tissue healing and resists and inhibits proteolytic enzymes, which break down proteins in the body.

This 60-year-old drug has now come of age and its anti-viral properties need to be confirmed in clinical trials.

— A fully referenced version of this report is posted on the ISIS website at *http://www.i-sis.org.uk*

Can traditional medicine help treat AIDS?

While billions of dollars have been pledged to help the worst affected, many of the poorest countries are still left without the medical support available in the West, and up to 80% of the population must rely on traditional medicine for primary health care. *SAM BURCHER* reports on some successes with a native herb.

Medicinal plants have been part of the great healing traditions around the world going back thousands of years, the best known being the Indian Ayurvedic medical system, Traditional Chinese Medicine and Western Herbal Medicine. These traditional medicines are the basis of a quarter of all drugs in today's modern pharmacy.

The World Health Organisation (WHO) defines Traditional Medicine as health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral-based medicines, spiritual therapies, manual techniques (e.g. reflexology) applied singularly or in combination to treat, diagnose and prevent illness or maintain well-being. In 2002 WHO launched its first comprehensive traditional medicine strategy to assist efforts to promote affordable, effective and safe use of Traditional Medicine (TM) and Complementary Alternative Medicine (CAM).

In Africa, TM is used by up to 80% of the population to meet primary healthcare needs and is crucial in the fight against infectious diseases. The ratio of a conventional, or Western-trained general practitioner (GP) to patients is 1: 20, 000, whereas the availability of TM practitioners is 1: 200 to 1: 400. This highlights the need for reliable and affordable herbal medicines that are locally available.

In South Africa, it is estimated that over 6 million people are living with HIV/AIDS and 150 babies are born with HIV every day. Conventional drugs exist for the treatment of HIV/AIDS, but they are only affordable by an estimated 1% of sufferers. Three out of four AIDS patients in Africa rely on some form of TM for treating the symptoms of HIV/AIDS (see Box 1).

Sutherlandia Frutescens (subspecies Microphylla) genus Fabaceae (pea and bean/leguminosae) is a perennial shrub that grows wild in the arid regions of Botswana, Namibia, Zululand, Western and Eastern Cape regions of Africa. *Sutherlandia* can grow up to 1.5 metres in height in optimum conditions of stony grasslands exposed to constant sunshine in daylight hours. A display of blood-red flowers bloom from June to December and its seeds are carried in greenish-red papery pods, which are almost transparent. The pinnate and compound-shaped leaves have a green-grey colour giving the bush a

Box 1: **Local Remedies to treat Symptoms in HIV/AIDS Patients**

Primary symptoms reported by HIV+ and AIDS Patients in Ngwelezane Hospital	Oral and topical Traditional Medicines prescribed to combat the primary symptoms of HIV and AIDS at Ngwelezne Hospital
Cough, cold, bronchitis	*Lippia javanica* (*umsuzwane*) fresh leaves to make tea infusion.
Chest pain	*Warburgia salutaris* (*isibaha*) two fresh leaves in tea infusion. Contraindicated in pregnancy.
Diarrhoea	*Psidium guajava* (*guava*) two crushed leaves with plenty of liquid. Discontinue when symptoms subside.
Itchy, painful rashes,	*Centella asiatica* (pennywort) fresh leaves blended with glycerine to make a cream.
Headaches, shortness of breath	*Artemisia afra* (*umhylonyane*) fresh aromatic leaves inhaled from a gauze bag to ease symptoms.
Loss of energy, weakness	*Hypoxis hemerocallidea* (*inkomfe*). Weak infusions made from the corms of the African potato make an excellent strengthening tonic, but must be used under medical supervision.
Loss of weight/appetite	*Sutherlandia* (*unwele*) tablets from dried leaves. One 300mg twice a day with meals (half dose for child).
Oral sores, body sores, swelling,	*Bulibine frutescens* (*ibhucu*) sap from leaves, applied directly or in a cream.
Throat infections	*Siphononchilus aethiopicus* (African ginger) (*indungulu*) Tablets made from the Rhizomes derived from fresh roots.

*Secondary symptoms reported by patients at Ngwelezane Clinic: abdominal pain, night sweats/fevers, urinary problems, nausea/vomiting and swollen glands. All the above recommended TM treatments were made by healthcare professionals at an HIV/AIDS clinic in South Africa .

silvery appearance.

The leaves and branches of the *Sutherlandia* bush are bitter to the taste, but are known traditionally to have health-giving properties. The dried leaves, containing four active compounds, are ground by traditional healers to make into tonics, teas, pills or creams (see Box 1). In the absence of easily available and affordable anti-retrovirals, these herbal treatments are used as the first line of defence in combating the symptoms of AIDS and other wasting diseases. Traditional Medicine practitioners who prescribe *Sutherlandia* are keen to preserve the use of the plant as a traditional medicine to maintain its patent-free status.

Conventional and traditional healers join up

An independent, inter-disciplinary partnership of TM healers, botanists, conventional doctors and scientists have joined up to form the group, PhytoNova, to prescribe and record the medicinal benefits of *Sutherlandia* in the treatment of HIV/AIDS symptoms. Dr Nigel Gericke, a GP and a botanist and his colleague Mr Credo Mutwa, 82-year-old traditional healer (sanusi), lead PhytoNova's clinical practice and laboratory in Cape Town, South Africa.

PhytoNova makes and supplies medicinal remedies derived from *Sutherlandia* for the treatment of HIV/AIDS symptoms direct to their own patients and to AIDS clinics in the region before a big pharmaceutical company can get their hands on it. Hundreds of AIDS patients have been treated by Gericke and Mutwa, who share the view that as long as they can prove that something is in the public domain, and is widely used to treat HIV/AIDS, then no one can come along and patent it for profit.

The price to Africans for a month's supply of pills made from the *Sutherlandia* bush is £2.50, and the powder form of the dried leaves, which is thought to be more effective because of its bitter taste, costs less than 60p for two months' supply.

Gericke describes the promoting of weight gain in wasted, full-blown AIDS patient as *Sutherlandia's* principal and most valuable medicinal property. Frequent significant and often sustainable gains in weight have been recorded in HIV patients taking Sutherlandia tablets. Weight records of 244 patients receiving treatment of *Sutherlandia* between November 1999 and September 2002 are available from the HIV and AIDS clinic in the Ngwelezane Hospital. Weight increases of up to 15 kg were reported in the majority and in some cases gains of 3-5kgs were sustained over the entire record-keeping period. This physiological boost has an immediate effect of enhancing energy levels and improving the patient's mood. Gericke said: 'We have seen several examples of bed-ridden patients able to get up after a month's treatment and even to return to subsistence farming.' Other AIDS patients who were told to 'go away and die' are delighted to find themselves still alive three years on after being treated by Mutwa. This anecdotal evidence supports the theory that AIDS may have become a chronic illness rather than a fatal one.

Gericke informed South African government scientists of the benefits of *Sutherlandia*. These include improvements in appetite, weight gain, sleep, exercise tolerance, anxiety and an overall sense of well-being. But 'because it was a tonic, the scientists dismissed it. They always rush, with classical reductionist thinking, to look for the magic ingredient', said Gericke, summing up the reality that HIV/AIDS itself is so complex, that it is increasingly apparent that there is no 'one-stop' solution for its treatment. Gericke has also appealed to his government to grow the bush on a massive scale, to mobilise a public health drive, but this too was ignored. To protect wildstocks of the plant from over-harvesting in the region, he has contracted local farmers to grow acres of *Sutherlandia* shrubs. This precautionary approach has created local employment and maintained the 'not at risk' status of *Sutherlandia* as a medicinal plant.

PhytoNova is convinced that progression to AIDS from HIV can be delayed once the patient has agreed to receive the appropriate treatment and doses of *Sutherlandia*, which are taken on an ongoing basis, in addition to careful attention to diet. It is recommended that alcohol; recreational drugs and other drugs that damage the immune system should be avoided. Anne Hutchings, an ethno-botanist and researcher of traditional Zulu medicine at the University of Zululand, who works in the weekly HIV and AIDS clinic at Ngwelezane Hospital, supports these prescriptions. She uses *Sutherlandia*-derived products from PhytoNova in addition to her own remedies made up from local plants (see Box 1). She started with just 11 patients in 1999 and now has more than 400.

In 2001, a community-based AIDS hospice in Emoyeni, South

Box 2: **Medicinal compounds isolated from the leaves of *Sutherlandia frutescens* (subspecies *microphylla*)**

L-Canavanine is a potent non-protein amino acid, l-arginine antagonist with documented anti-viral, anti-bacterial, anti-fungal and anti-cancer activities. L-canavanine has patented anti-viral activity against influenza and retrovirus, including HIV. A US patent registered in 1988 claims selective destruction of 95% HIV-infected lymphocytes *in vitro*.

Pinitol is a known anti-diabetic agent, described in its 1996 patent as having some benefits in the clinical application of treating wasting in cancer and HIV/AIDS.

GABA is an inhibitory neurotransmitter. This could account for *Sutherlandia's* success in treating anxiety, stress and depression and for observed improvements in mood and well-being experienced by patients taking preparations from the plant.

SU1 is a novel triterpenoid isolated by members of the Phyto Nova team, which is showing promising biological activity.

Africa, admitted 71 AIDS patients for terminal care. Sister Pricilla Dlamini treated the patients with *Sutherlandia* pills and infusions of another local plant often referred to as African potato (*Hypoxis Hermerocallidea*). PhytoNova tracked the progress of her patients one year later. Of the 71 patients, 30 had been discharged as healthy back into the community. Some have since returned for follow-up treatments with *Sutherlandia* while others have been lost to follow-up treatments. No adverse events were reported.

Virginia Rathele is a nurse and Zulu traditional healer (sangoma) in the Northern Cape town of Kuruman. She is using *Sutherlandia* pills to treat 300 AIDS patients in her clinic. She says, '*Sutherlandia* does not work properly just on a diet of porridge. You have to have vegetables.' One of her patients was close to death and weighed only 26kg, but after receiving treatment and an improved diet now weighs 45kg and is helping to run the clinic. Rathele is also keen to keep the plant patent-free and believes the treatment should be accessible to everyone.

Traditional medicine dispels the darkness

Historically, *Sutherlandia* has been called many names and used for many purposes. The indigenous Koi San tribes-people name it *Insiswa*, meaning 'the one that dispels darkness'. *Insiswa* has been used for centuries as an energy booster and anti-depressant. Sangomas know the plant as *unwele*, a 'great medicine' which so uplifts your spirit that you will not want to tear your hair out and was prescribed for the widows of Zulu warriors. The name 'cancer bush' or *kankerbos* is another name ascribed to *Sutherlandia* by Afrikaners and attests to a traditional use as a cancer remedy. *Sutherlandia* came to the attention of British botanists when Zulu sangomas used it against the 1918 influenza pandemic that killed 20 million worldwide. The English version of *Sutherlandia* was named after James Sutherland, the first superintendent of the Edinburgh Botanical Gardens.

Sutherlandia has a 'beautiful portfolio of chemicals', says Gericke (see Box 2). He has analysed and identified a range of chemicals, which have been previously used for the treatment of patients with cancer, TB, diabetes, schizophrenia and depression and as an anti-retroviral agent. Some of these molecules, already identified from sources other than *Sutherlandia*, have US patents attached to them for their use in treatment of these diseases. Gericke recognises the great potential of the plant's chemistry and says: 'The claim we are making on the basis of this, is that we can dramatically improve the quality of life of many AIDS patients. We are certainly not making the absurd claim that *Sutherlandia* is a cure-all or a cure for AIDS.'

The medical records of a patient who had ceased taking conventional anti-retrovirals to combat symptoms of HIV/AIDS for two years before turning to PhytoNova for treatments using *Sutherlandia* pills were documented. These show a marked decrease in the patient's viral load and a significant increase of his CD4 lymphocyte cell count over a six-week period. His starting CD4 count in May 2001 was 340, which increased to 647 in June 2001. During the same period his viral load decreased from 25,000 to 9,200.

A study on toxicity

To date, no severe adverse reactions to *Sutherlandia* in any form has ever been reported. Nevertheless an independent safety study was conducted by South Africa's Medical Research Council because of the significant ethno-botanical background and availability of the plant as well as the severity of the HIV/AIDS problem in the region. The study tested the effect of *Sutherlandia* on 16 vervet monkeys in four groups including one control. The monkeys were fed with dried *Sutherlandia* leaf powder for three months and exhibited no single indication of toxicity even in the group fed nine times the dose prescribed for the treatment of AIDS in humans. A massive dose of 1x 500mg/kg by mouth was administered without any adverse effect. This is the first South African medicinal plant to be evaluated for toxicity using primates in a controlled study.

The Indigenous Knowledge Systems Division (IKS) of the MRC in South Africa is committed to the scientific and clinical validation of promising indigenous medicinal plants. *Sutherlandia* is considered by IKS to have a long history of medicinal use going back at least 105 years. It acknowledges that a tonic made from the plants may be of value to people living with HIV/AIDS in terms of enhanced well-being, increased appetite and body mass as well as increased tolerance for exercise. Use of *Sutherlandia* is contraindicated in pregnancy.

The IKS was formed in 2001, and has created successful collaborations with traditional healers across the regions of Africa. So far they have identified 20 traditional healers across the region from the 300,000 that are estimated to exist on the continent. The select healers are encouraged to keep records of their consultations and it is hoped they will train other healers to do so. A medicinal garden project has also been started where plants can be cultivated and identified. A library and computers systems are also being developed alongside a TM database called TRAMED III, which incorporates medicinal plant monographs.

Not all testimonies to the powers of *Sutherlandia* are glowing. Stuart Thomson, director of Gaia Research, has attacked the plant, the MRC trials and PhytoNova. He says *Sutherlandia* is a 'poison panacea' and PhytoNova is unlawfully distributing a substance, which he believes is potentially toxic as well as using people as human guinea pigs. Thomson considers the MRC study to be invalid because the monkeys were not infected with HIV/AIDS and were studied for less than six months. He also raises some questions on the safety of L-Canavanine (see Box 2). But *Sutherlandia* taken under allopathic or traditional medical guidance would certainly seem to offer an alternative to sludgy liquids made of

industrial solvents which sell on the streets of Johannesburg like hot cakes by those looking to exploit the numbers of desperate people living with HIV /AIDS.

Of course, there are plants among Africa's flora and fauna that are toxic and efforts are being made to study and document these to avoid incorrect TM treatment of HIV/AIDS or indeed any illness. One such plant recorded to have toxic properties is *Callilepis Laurealo* or *Impila*.

One *Sutherlandia* plant can treat 10 people

Mutwa of PhytoNova says cultivating *Sutherlandia* is a question of sanding each little seed with fine sandpaper; planting, watering and letting them grow. He refuses to see his country destroyed by HIV and AIDS when nobody really knows the origins of the disease. He reminds critics that the bark of the Cinchona tree forms the natural chemical basis of quinine which, when used correctly, is a successful treatment of malaria for many. Since resistance to quinine has become more prevalent, the shrub Artemesia was discovered to contain Artemisian, an alkaloid with even great efficacy for the treatment of mefloquinine-resistant strains of malaria.

The MRC also plans a pilot clinical trial involving 50 people on the medicinal effects of *Sutherlandia*. This was scheduled to begin in February 2002, pending a decision by the Government's Medical Approval Council. The Director of the IKS Dr Matlalepula Matsabisa told the *New Scientist*, 'A trial like this could act as a valuable template for other trials.' He said, 'The fact is people are already using it and will continue to whether or not the government approves trials.' It appears that Africa's first-line treatment of HIV/AIDS is *Sutherlandia*, local to the regions where it is needed the most, whose history as a beneficial, though bitter, Traditional Medicine puts it firmly in the hands of the people.

A fully referenced version of this report is posted on the ISIS website.

'Pink Panacea', at last a vaccine against AIDS?

***SAM BURCHER* reports on an unconventional vaccine that could provide treatment for AIDS.**

A company based in Thailand has developed an oral vaccine against HIV/AIDS. The makers of a pink pill called 'V1' claim striking success in the treatment of HIV/AIDS symptoms.

Immunitor Corporation Company and V1's creators are clinical researcher Dr Aldar S. Bourinbaiar and pharmacist Vichai Jirathitikal, who have put V1 through a placebo-controlled phase II study. The results showed significant improvements in CD4 and CD8 cell counts, weight gain, decreased viral load and survival of end-stage AIDS patients. It also suggested that the V1 could reverse the progression of AIDS without concurrent toxicity.

Immunitor and Dr Orapun Metadilogkul, an independent physician who heads the Thailand Association of Occupational and Environmental Medicine Physicians, claim that 27 patients diagnosed with HIV/AIDS have seroconverted from HIV-positive to HIV-negative after treatment with V1. A phase III trial application has been submitted to the Thai Food and Drug Administration (FDA) aimed at demonstrating the beneficial properties of V1 on associated symptoms of AIDS such as wasting. If approved, trials will take place at the largest public hospital in Bangkok under Dr Metadilogkul.

V1 is said to be a therapeutic vaccine comprising 'HIV antigens from pooled clinical isolates from HIV-infected donors'. These antigens are made into pills taken orally that do not degrade in the digestion process of the stomach, but trigger immune responses in the underlying mucosa-associated immune cells in the lining of the small intestine.

Some 90% of the immune cells in the human body are made up of lymphocytes and monocytes in the lining of the mucosal surfaces. So there are ten times more CD4 and CD8 lymphocytes residing in the mucosal lining than in the blood where only 2% of lymphocytes are present. According to Immunitor, these intestinal cells are the front-line defence against HIV and are the first to be destroyed or disabled by the virus.

Once mucosal immunity has failed, the common and often fatal symptoms of HIV/AIDS appear, such as diarrhoea and respiratory infections. V1 works on the premise that HIV/AIDS is a disease of mucosal immunity, so targeting antigens at mucosal surfaces is a valid clinical approach.

Public opinion on V1 came sharply into focus when Thai clinics began giving out the pink pills free of charge to AIDS patients at mass rallies organised in schools, police stations, sport stadiums and Buddhist temples. There was opposition to these actions by a number of workers in conventional medical practices, despite the fact that they have no effective treatment to offer to patients with HIV/AIDS.

Positive results

V1 is extensively subject to toxicity studies both *in vitro* and *in vivo*. So far, studies by the Thai government and independent private laboratories have proved it exhibits no toxicity. Five mammalian cell lines tested at the highest dose of 10mg/ml showed no sign of cytotoxicity. The extrapolated dose of V1 that would cause death in

humans is 2,200 pills per day, as against the recommended daily dose for adults of one or two pills per day.

Recently published data from Immunitor shows that 40 AIDS patients on a six-month trial of V1 treatment increased their CD4 and CD8 cell counts by a mean average of 51 cells (19%) per microlitre of blood. Increase in body weight was 2.2 kg on average. But some patients' weight increased by as much as 30 kg, which is an important gain in the treatment of AIDS.

These encouraging results led Bourinbaiar and Jirathitikal to evaluate V1 therapy in the treatment of terminally ill AIDS patients in intensive care wards in Thai hospitals. They approached 117 patients and 53 decided to take V1 while 64 declined treatment. All patients were bedridden and had been receiving palliative care. None of the patients had access to conventional anti-retroviral drugs, but some had been treated with antibiotics. All the patients in the non-V1 group were dead by week 9. In contrast 30 out of the 53 in the V1 group were alive and able to resume normal activity.

After 20 months on V1, 18% of patients who started with almost zero CD4 counts were still alive. It was also noted that patients receiving V1 seldom developed opportunistic infections, which further suggests that V1 improves mucosal immune responses to infections.

A retrospective analysis by Bourinbaiar and Jirathitikal of 650 HIV-positive patients who had taken V1 for an average of 23 weeks showed significant results. In total, 496 (76%) were able to increase their body weight or at least maintain weight on the V1 regime; 389 (59%) gained 4.2 kg, while 107 (17%) remained unchanged and 159 (24%) lost weight. Everyone participating in the trial was able to remain on it and suffered no serious side effects.

A further study took place whereby V1 was administered to the HIV-negative relatives of terminally ill AIDS patients over a median period of 24 days. Their blood was then transfused into the AIDS patients who experienced an improvement in their health. Results showed that increases in CD4 and CD8 counts were statistically significant.

Ideal in Third World conditions

V1 is currently licensed as a food supplement by the Thai Food and Drug Federation (FDA) and is produced for R&D purposes. A one-month supply costs around $20-£30 per person, but it is given freely to poor patients in public hospitals wherever possible. So far 65,000 Thais infected with HIV have been given the treatment.

Costs for V1 contrast strikingly with those of more established combination therapies or 'cocktails' consisting of three-drug antiretroviral treatments of HIV/AIDS. A recent HIV Cost Services Utilisation Study Consortium Analysis estimates that in the USA, 33,500 HIV-infected adults seen twice a year for medications and blood tests spend $6.7 billion or $22,000 per patient per year.

Apart from the economic viability of V1, there may be other advantages when considering its use as a safe therapy for the developing world. It has broad-spectrum activity against many HIV subtypes and is stable in ambient tropical temperatures for three years, making refrigeration unnecessary. And no special skills or syringes are needed to administer the pill.

Immunitor is not disclosing the medicinal properties of V1, but instead recommends a cocktail of V1 and certain generic drugs as alternative and inexpensive treatments for HIV/AIDS. They cite examples of five compounds: gramicidin (the first antibiotic to be isolated), cimetidine (Tagamet), warfarin (a common anti-coagulant), levamisole (an animal de-wormer), originally developed for animal use, but latterly became a useful drug in treating colon cancer in humans, and acetaminophen (Paracetamol). Immunitor says these unapproved drugs are all highly effective against HIV/AIDS and are incredibly cheap in comparison to approved combination therapies. (See article 'Alternative AIDS Therapy from Cheap Generics'.)

Clinical trials of V1 are ongoing and phase III trials are scheduled for Africa with results pending. It is registered in Ghana and licences have been applied for in several other African states. Immunitor hopes to build a vaccine plant to supply large amounts of V1 to Africans at low cost. This would meet a critical demand for affordable and available HIV/AIDS treatment in the continent.

Much attention is centred on the high rates of infection and death, 95%, caused by HIV/AIDS in the developing world. But until recently the intimate association between the pandemic and poverty has been played down in the application of strategic approaches for HIV/AIDS. In his recent letter to *The Times* newspaper Prof. Kenneth Stuart, the medical adviser to the Commonwealth Secretariat, highlighted the need to recognise the role of poverty in effective treatments for HIV/AIDS. He says, 'The more the gap widens between rich and poor the greater the number of people who are left stranded in the backwaters of progress.' So not only are people in poverty traps deprived access to helpful technologies and medicines, their ability to acquire knowledge is diminished along with their human rights.

The report *Thailand Social Monitor: Poverty and Public Policy* says 16% of the country's population, or about 10 million people, are now living on less than the minimal income of Bt900 per person per month, which constitutes the country's poverty line.

'Poverty is re-emerging as one of the nation's most serious problems,' said Ian Porter, the World Bank's country director for Thailand, at the launch of the new report, which was jointly prepared by the National Economic and Social Development Board, the Thailand Development Research Institute and international experts.

Vatican: condoms don't stop AIDS

Steve Bradshaw

The Catholic Church is telling people in countries stricken by Aids not to use condoms because they have tiny holes in them through which HIV can pass — potentially exposing thousands of people to risk. The church is making the claims across four continents despite a widespread scientific consensus that condoms are impermeable to HIV.

A senior Vatican spokesman backs the claims about permeable condoms, despite assurances by the World Health Organisation that they are untrue.

The church's claims are revealed in a BBC I Panorama programme, Sex and the Holy City. The president of the Vatican's Pontifical Council for the Family, Cardinal Alfonso Lopez Trujillo, told the programme: 'The Aids virus is roughly 450 times smaller than the spermatozoon. The spermatozoon can easily pass through the 'net' that is formed by the condom.

'These margins of uncertainty... should represent an obligation on the part of the health ministries and all these campaigns to act in the same way as they do with regard to cigarettes, which they state to be a danger'.

The WHO has condemned the Vatican's views, saying: 'These incorrect statements about condoms and HIV are dangerous when we are facing a global pandemic which has already killed more than 20 million people, and currently affects at least 42 million'. The organisation says 'consistent and correct' condom use reduces the risk of HIV infection by 90%. There may be breakage or slippage of condoms — but not, the WHO says, holes through which the virus can pass .

Scientific research by a group including the US National Institutes of Health and the WHO found 'intact condoms... are essentially impermeable to particles the size of STD pathogens including the smallest sexually transmitted virus... condoms provide a highly effective barrier to transmission of particles of similar size to those of the smallest STD viruses'.

The Vatican's Cardinal Trujillo said: 'They are wrong about that... this is an easily recognisable fact'. The church opposes any kind of contraception because it claims it breaks the link between sex and procreation — a position Pope John Paul II has fought to defend.

In Kenya — where an estimated 20% of people have HIV — the church condemns condoms for promoting promiscuity and repeats the claim about permeability. The archbishop of Nairobi, Raphael Ndingi Nzeki, said: 'Aids... has grown so fast because of the availability of condoms'.

Sex and the Holy City includes a Catholic nun advising her HIV- infected choirmaster against using condoms with his wife because 'the virus can pass through'.

In Lwak, near Lake Victoria, the director of an AIDS testing centre says he cannot distribute condoms because of church opposition. Gordon Wambi told the programme: 'Some priests have even been saying that condoms are laced with HIV/AIDS'.

Panorama found the claims about permeable condoms repeated by Catholics as far apart as Asia and Latin America. — *The Guardian* (UK) 9 October 2003

Steve Bradshaw is a correspondent with *Panorama*.

Abstinence works against AIDS

Pia de Solenni

Every 14 seconds a young person is infected with HIV, according to a U.N. Population Fund Assistance report recently released. Given that the Catholic Church provides 25% of HIV/AIDS care worldwide, many of these young people will be cared for by the Catholic Church. No state, government, or individual matches this commitment. Yet the BBC in its program 'Sex and the Holy City', which aired in Britain on Monday, all but implicated the Church and Pope John Paul II in the spread of HIV throughout the world.

The Catholic Church's teaching on condoms appear to baffle BBC producers and their ilk. However, the wisdom of this precept has been confirmed by science. Or perhaps it's better to say that science has not been able to confirm the wisdom of condoms. In June 2000, the U.S. National Institutes of Health sponsored a workshop to survey the evidence on condom effectiveness. The final report, released in July 2001, concluded that the consistent and correct use of male condoms provides an 85% reduction in HIV/AIDS transmission between women and men.

Assuming a scenario in which condoms are used consistently and correctly for every sexual act, there's still no guarantee that the condoms themselves are in fact effective against HIV infection. According to the CDC, only latex or polyurethane condoms provide a barrier against HIV. There are many other type of condoms available throughout the world. In 2002, Tanzania reportedly rejected 10 million condoms provided by UNFPA because they were defective. Quite simply, they leaked. While the BBC and condom advocates would suggest one type of behavior change, namely correct and consistent condom usage, the Catholic Church proposes another type of behavior change: abstinence, monogamy and fidelity.

Here again, science weighs in on the side of religion. Botswana and Zimbabwe are ranked among the top countries world-wide for HIV prevalence. Yet both countries are condom-friendly and make condoms readily available.

In 1991, Uganda also had an HIV infection rate of more than 20%. By 2001, however, the rate was only 6%. A 2002 Harvard study conducted by anthropologist Edward C. Green and Vinand Nantulya, an infectious-disease specialist, revealed the cause of the discrepancies between Uganda's HIV infection rate and those of other heavily infected countries. Uganda had begun a program focusing on abstinence and fidelity. While the rate of HIV infection in every other country continued to escalate, Uganda's fell dramatically.

The health experts showcased by the BBC would do well to familiarize themselves with the relevant scientific data and the BBC would do well to put into practice the principle of truth in journalism. Although the data confirms something taught from a religious perspective, by no means does it render the science invalid. Only bias could create an incompatibility between religion and science. Only unadulterated bias would do so at the risk of millions of lives. — *Asian Wall Street Journal,* 16 October 2003

Ms. De Solenni is the director of life and women's issues at the Family Research Council, Washington, D. C.

Asian People's Charter on HIV/AIDS

This document initiated and facilitated by the Peoples' Health Movement was built through a consultative process at various meetings, conferences and workshops; at the local, national and international levels. It was finalised and presented publicly for endorsement in Geneva during the World Health assembly.

This Charter will be officially launched at the XV International AIDS Conference, 11-16 July 2004.

We urge you to publicise, and use it in your campaign and advocacy activities.

Introduction

HIV is recognised as a 'global development emergency' destabilising societies and economies, thus threatening millions of lives, especially in some of the world's most populous nations. The AIDS pandemic is one of the greatest humanitarian crises of all times. It has caused death and misery, destroyed families and communities and ravaged entire populations. HIV/AIDS is already wiping out a generation in Africa. Two decades after it began its onslaught in Sub-Saharan Africa, the disease has been spreading fast. It has gained a firm foothold in other places like in parts of Asia, etc.

Africa's experience shows that HIV/AIDS, in a single stroke, can destroy development gains of several decades as well as the social composition of people. A similar tragedy is unfolding in other parts of the world. Spreading along migration routes related to globalisation and to social and economic distress due to war, global trade and economic policies, HIV/AIDS is now associated with the resurgence of other communicable diseases of poverty, such as tuberculosis.

The Alma Ata Declaration of 1978 promised Health for All by 2000. HIV/AIDS was not a key issue in 1978. While HIV/AIDS has contributed in negatively affecting this goal, the total breakdown of the public health system and primary health care during the 1980s and 1990s has amplified the spread and impact.

The People's Health Movement (PHM) considers HIV/AIDS as a public health issue. However, PHM believes that the way to combat HIV/AIDS is not through just a medical approach, but through better politics, care, research, pro-people policies, rights and governance and effective communication.

Access to ARV treatment has increased the life expectancy and quality of life of those who can afford it. The majority of AIDS patients being impoverished are denied access to treatment in violation of the principles of the International Covenant on Economic, Social and Cultural Rights. Children orphaned by HIV/AIDS and women being more vulnerable, take a heavy toll.

Preamble

Health is a social, economic and political issue and above all a fundamental human right. Inequality, poverty, exploitation, violence and injustice are at the root of ill-health and the deaths of poor and marginalised people. Health for All means that the powerful interests have to be challenged, globalisation has to be opposed, and political and economic priorities have to be drastically changed. HIV/AIDS is a public health issue that calls for medical, social and political responses.

This charter builds on the perspectives of people who are affected, infected, suffering from and living with HIV/AIDS. It encourages people to develop their own solutions and hold accountable the local authorities, national governments, international organisations and corporations.

Vision

Equity, ecologically-sustainable development and peace are at the heart of our vision of a better world – a world in which a healthy life for all is a reality; a world that respects, appreciates and celebrates all life and diversity; a world that enables the flowering of people's talents and abilities to enrich each other; a world in which people's voices guide the decisions that

shape our lives.

Resources are in abundance to achieve this vision.

Principles of this charter

This charter calls for:

Action by People's Health Movement and Civil Society:

♦ CONTINUE campaigns for the rights of people in poor countries to receive ARV treatment delivered through comprehensive PHC services

♦ FACILITATE public interest litigations to oppose changes in patent laws that are expected to escalate the ART prices

♦ MAKE links between the spread of HIV/AIDS and the underlying societal determinants such as poverty, war and displacement, and participate in efforts to redress these injustices.

Action by Governments:

♦ DEVELOP a comprehensive Primary Health Care-oriented and health systems-strengthening approach to address the HIV/AIDS epidemic through interventions, including:

— Peer education inclusive of sexual and reproductive health and rights information

— Oppose stigma and promote respect and care for people living with HIV/AIDS

— Increased access to basic services by people living with HIV/AIDS

— Immediate availability of ARV drugs

— Support those affected by the epidemic through empowerment

— Allocate more resources for primary health care in general and communicable diseases in particular

— Reduce the budget for factors like military expenditure that amplify public health and HIV/AIDS crisis

— Place people above profits and politics and thus take control of policies that affect people's lives in general and people infected, affected, suffering (from) and living with HIV/AIDS

— Develop a transparent, scientific and human way to conduct clinical trials through an informed consent approach.

Action by WHO:

♦ EVOLVE a comprehensive approach emphasising Primary Health Care and health systems-strengthening approaches including preventive information and services and ARV treatment

♦ WORK towards reduction of high drug costs

♦ ENHANCE involvement of people, affected communities and civil society in its planning and initiatives through proactive dialogue

♦ NEED for:

— a paradigm shift. WHO's 3x5 initiative [that promises 3 million persons with AIDS receiving ARV treatment by 2005] requires contextual solutions. The 3x5 initiative at present focuses on treatment alone, ignoring the complexity of the epidemic

— low-cost drugs. High drug costs can lead to long-term dependency on donors

— adequate involvement of persons living with and affected by HIV/AIDS and civil society in planning, implementation and evaluation

— adequate budgetary and related commitments on improving health systems, particularly Primary Health Care to provide drugs and general health services and information in the long term

— adequate attention to life skill education, women's health empowerment and utilisation of traditional systems of medicine.

Action by UNAIDS:

♦ HIGHLIGHT the cost of inaction in 'so-called low prevalence countries'

♦ DEVELOP a specific global programme strategy to address the prevention and care needs of 'so-called low prevalence countries'

♦ ADDRESS its own shortcomings in using the in-country UN Theme groups effectively. Several in-country UN Theme groups have yet to sign a framework for collaboration with the national governments

♦ FACILITATE international and national NGOs evaluating and monitoring the efficacy of country-level supports of the UN Theme groups

♦ FACILITATE a regional and national score card of UN Theme groups

♦ CHAMPION the cause of non-priority countries of the 3x5 initiative.

People's Health Movement
Global Secretariat, c/o CHC,
367, Jakkasandra 1st Main, 1st Block, Koramangala,
Bangalore – 560 034, INDIA

Tel : +91-80-51280009 Fax : +91-80-25525372
Email: *secretariat@phmovement.org*
Website: *www.phmovement.org*

The Mumbai Declaration

The following declaration came from an international meeting (the III International Forum for the Defence of the People's Health) of grassroots groups, mass movements and activists, concerned about health issues, at Mumbai from 14-15 January 2004. It derives its strength from the People's Health Movement Health Charter, the largest consensus document on health and the guiding spirit for the People's Health Movement.

Preamble

We, the 700 delegates from 44 countries[1], gathered at the III International Forum for the Defence of the People's Health at Mumbai on 14th and 15th of January 2004, reaffirm the validity and relevance of the People's Charter for Health, the foundational document of the People's Health Movement, which describes increasing and serious threats to health in the early 21st century.

Since the Charter's adoption in December 2000 at the first People's Health Assembly, at GK Savar, Bangladesh, the health of the world's poor has worsened and more threats to people's health have emerged.

Social, political, economic and environmental threats to health identified as the basic causes of ill health and the inequitable distribution of health within and between countries have increased.

The III International Forum for the Defense of the People's Health provided opportunities to hear inspiring testimonies, from the world's poor and health activists:

♦ Denouncing the denial of health to their communities and their efforts to overcome this injustice.

♦ Threats to health from the unfair system of global trade and the imperialist policies of developed countries including unjust wars and efforts to counter them

♦ The demands for acknowledgement of health as a universal human right and the implementation of Comprehensive Primary Health Care as a strategy to achieve Health for All.

The Forum recognised the particular discrimination suffered by many groups which makes achieving Health for All even more difficult. These included women, people with disabilities, sex workers, children living in difficult circumstances (including street children), migrant workers, people with mental disorders, Dalit people, Indigenous peoples in rich and poor countries, and all those affected by wars, disasters and conflicts. The Forum demanded Health for All, Now! and reiterated that another world in which health is a reality for all is necessary and possible.

The Forum brought together all the concerns and experiences shared into a Declaration for action, entitled 'The Mumbai Declaration'. This Declaration is an update on the state of people's health across the globe at the beginning of 2004 and calls on People's Health Movement, Civil Society and Governments to evolve action in six key areas to achieve the goal of 'Health for All Now!' dream.

♦ End corporate-led globalisation

♦ End war and occupation

♦ Implement Comprehensive and sustainable Primary Health Care

♦ Confront the HIV/AIDS epidemic with Primary Health Care and Health Systems approach

♦ Reverse environmental damage caused by unsustainable development strategies

♦ End discrimination in the Right to Health

End corporate-led globalisation

Corporate-led globalisation continues to be a major threat to health. Since the People's Charter for Health was adopted in 2000, the International Monetary Fund, the World Bank and the World Trade Organisation have continued to advance the economic health of corporations at the expense of global health.

The protection of intellectual property (through trade agreements such as the Trade-Related Aspects of Intellectual Property Rights, TRIPS) and unfair trading practices (through the General Agreement on Trade in Services, GATS) have caused enormous damage to people's health.

The tobacco industry offers a clear example: Tobacco kills, yet transnational companies continue to target youth and marginalised communities with their tobacco marketing strategies.

The epidemic of privatisations of water, electricity, education and health care, imposed by Structural Adjustment Programmes (SAPs), has limited access to or removed the foundation upon which public health is built.

Public-private partnerships, as promoted by World Bank, global funds and international health agencies including WHO, have removed responsibility for health from the public sector, essentially privatising health and treating it as a commodity rather than a human right. User fees have further decreased people's access to health care services.

This Declaration:

Calls for Action by People's Health Movement and Civil Society to:

♦ Pressure the World Bank and the International Monetary Fund to acknowledge their culpability in the current health care crisis, especially the damage caused by Structural Adjustment Programmes;

♦ Build the Campaign 'No To Intellectual Property Rights' in our traditional systems of medicine and our seeds, to resist the efforts of the WTO and translational corporations to patent, own and trade in them;

♦ Demand the representation and active participation of people's organisations, health workers, and farmers in policy-making processes related to Access to Health

♦ Expose, shame and stop government officials, academic institutions, and civil society organisations from accepting money from the tobacco and other industries which undermine public interest initiatives internationally and nationally.

Calls for Action by Governments:

♦ Regulate the entry and behaviour of the corporate sector in the social services such as health, education, transportation, etc., and ensure that public health concerns always take precedence over trade agreements and corporate profit;

♦ Resist 'TRIPS-plus' through bilateral or regional trade agreements driven by the United States government and the institutions it controls;

♦ Ensure negotiations on 'Free Trade' treaties and the like are transparent and democratic and not conducted behind closed doors;

♦ Resist pressure to privatise health essential industries (health care, electricity, water and education) and renationalise these industries;

♦ Sign, ratify and implement the Framework Convention on Tobacco Control (FCTC).

End war and occupation

Since 2000, war, occupation and militarism have become ever more devastating threats to people's health. The violent imposition of imperial will has led to death, injury, and social and environmental destruction for untold numbers of people.

Actions in support of international law and pro-health and against the war in Iraq; the occupation of Iraq and Palestine; the construction of the Wall in Palestine are urgently needed.

This Declaration:

Calls for Action by People's Health Movement and Civil Society to:

Strengthen the international anti-war movement through:

♦ Building the global campaign: 'No to War, No to WTO, Fight for People's Health';

♦ Monitoring the impact of war, occupation, and militariaation through a global 'Occupation Watch';

♦ Targeting corporations which benefit from the war in Iraq, invasions and military occupations and those that enrich themselves (e.g. arms industry, pharmaceutical and food companies) by fostering ill-health through a 'Boycott Bush' campaign;

♦ Establish peace initiatives at various levels based on justice and equality.

Calls for Action by Governments:

♦ Refuse to take part in unjust and imperialist wars and occupations

♦ Work for world peace as a key determinant of health.

Implement Comprehensive and Sustainable Primary Health Care

Since 2000, the Global Fund and other international health programmes of WHO, UNICEF and World Bank have continued to promote selective and vertical health programmes which corrupt and weaken Comprehensive Primary Health Care as defined in the WHO Alma Ata Declaration.

Health professionals educated in the developing world and migrating to the developed world represent a transfer of billions of dollars from South to North. This unrequited training investment further burdens health systems already suffering from a precarious lack of human resources. The 'brain drain' flows not only from developing to developed countries, but also from the public to the private sector.

Traditional and alternative systems of medicine are vibrant parts of Comprehensive Primary Health Care. Traditional Birth Attendants provide the first and often the only access to reproductive health in many areas of the world. These knowledge and traditions should be validated and their skills reinforced through continuing education, and support to the revitalisation of local health traditions.

New areas, relevant to Primary Health Care, not adequately addressed in the Alma Ata Declaration need to be promoted in an integrated way. These include gender, environment, disability, mental health and traditional systems of health.

This Declaration:

Calls for Action by People's Health Movement and Civil Society to:

♦ Demand that universities and other training institutions incorporate Comprehensive Primary Health Care into the curriculum for all health professionals updated to address gender, environment, disability, mental health, traditional systems and other issues;

♦ Lobby for widespread adoption of Community Health Workers and Traditional Birth Attendants as integral members of multi-disciplinary Primary Health Care teams.

Calls for Action by Governments:

♦ Develop national policies on traditional and alternative medical systems and include them in national health programmes;

♦ Involve marginalised sectors in decision-making regarding policies that affect them;

♦ Strengthen health systems in the context of access, quality and equity;

♦ Establish Comprehensive Primary Health Care services based on the principles and strategies of Alma Ata outlined in this declaration and related to local needs and updated to address gender, environment, disability, mental health, traditional systems and other issues.

Calls for Action by WHO:

To reaffirm the principles of Alma Ata and ensure that comprehensive approaches that focus on primary health care and strengthen health systems are the basis of all WHO global and regional strategies.

Confront the HIV/AIDS epidemic

The HIV/AIDS epidemic has continued to worsen since 2000, especially in Africa and increasingly in Asia and elsewhere. Spreading along migration routes related to globalisation and to social and economic distress due to war, global trade and economic policies, HIV/AIDS is now associated with the resurgence of other communicable diseases of poverty, such as tuberculosis.

Access to ARV treatment has increased the life expectancy and quality of life of those who can afford it. The majority of AIDS patients being impoverished are denied access to treatment in violation of the principles of the International Covenant on Economic, Social and Cultural Rights. Children orphaned by HIV/AIDS and women who are more vulnerable take a heavy toll.

WHO has recently become stronger in its technical support to HIV/AIDS and has made an official commitment to pursue its 3 x 5 goal (3 million persons with AIDS receiving anti-retroviral treatment (ARV) treatment by 2005) through strengthened health systems. Yet addressing the HIV/AIDS epidemic requires contextual solutions. We are, however, particularly concerned that:

♦ The 3 x 5 initiative focuses on treatment alone, ignoring the complexity of the epidemic;

♦ High drug costs can lead to long-term dependency on donors;

♦ There are inadequate involvement of persons living with and affected by HIV/AIDS and civil society in planning, implementation and evaluation

♦ There are inadequate budgetary and related commitments on improving health systems, particularly Primary Health Care to provide drugs and general health services and information in the long term.

♦ There is inadequate attention to life skill education, women's health empowerment and utilisation of traditional systems of medicine.

While endorsing concern about the HIV/AIDS epidemic, the need for Primary Health Care oriented and Health Systems strengthening approaches to other communicable and non-communicable diseases in an integrated way is urgently required.

This Declaration:

Calls for Action by People's Health Movement and Civil Society to:

♦ Continue campaigns for the rights of people in poor countries to receive ARV treatment delivered through comprehensive PHC services.

♦ Facilitate public interest litigations to oppose changes in patent laws that are expected to escalate the ART prices.

♦ Make the links between the spread of HIV/AIDS and the underlying societal determinants such as poverty, war, displacement, and participate in efforts to redress these injustices

Calls for Action by Governments:

♦ Develop a comprehensive Primary Health Care oriented and health systems strengthening approach to address the HIV/AIDS epidemic through interventions, including:

♦ Peer education that includes sexual and reproductive health and rights information;

♦ Oppose stigma and promote respect of and care for people living with HIV/AIDS;

♦ Increased access to basic services by people living with HIV/AIDS;

♦ Immediate availability of ARV drugs;

♦ Support those affected by the epidemic through empowerment.

Calls to WHO:

♦ To evolve a comprehensive approach emphasising Primary Health Care and health systems strengthening approaches including preventive information and services and ARV treatment;

♦ Work towards reduction of high drug costs;

♦ Enhance involvement of people, affected communities and civil society in its planning and initiatives through proactive dialogue.

Reverse Environmental Destruction

The People's Charter for Health recognized that environment, livelihood, and people's health are interconnected and environmental degradation is a major threat to global health. Since 2000, continuing environmental destruction has had a highly negative impact on health. Rivers around the world, like the Abra in the Philippines and the Narmada in India, are in danger of being destroyed, as are the lives and health of the people and communities who depend on these rivers.

Toxins in pesticides, fertilizers, defoliants (such as Agent Orange and those of the 'War on Drugs' of Plan Colombia), waste from US Military Bases (such as those in the Philippines), dust from exploded depleted uranium ordinance (such as that used in Iraq,

Puerto Rico), and medical and nuclear waste as well as from mining run-off and exploration for petroleum; are all poisoning our environment and represent a critical hazard to health.

Calls for Action by People's Health Movement and Civil Society to:

♦ Monitor environmental damage caused by unsustainable development strategies with specific focus on pesticides, industrial and military toxic wastes, etc.;

♦ Link PHM with other organisations working for environmental justice at the grassroots,

♦ national and international levels. Join them in their struggles and invite them to join in our struggle for the People's Health.

Calls for Action by Governments:

♦ Pass legislation to ensure governments can hold corporations accountable for environmental damages.

End Discrimination in the Right to Health

The People's Health Charter asserted the right to health for all people. We reaffirm this by noting that the marginalized groups listed below suffer particular and on-going health problems requiring urgent attention:

♦ Around the world, many women lack access to basic health care, endangering them and their families. Women's right to health, including sexual and reproductive health, is violated not only by current socio-economic and political structures but also by religious and cultural fundamentalism. Population control policies violated human rights, including the use of disincentives and such reprehensible practices as forced sterilization of women. Newer contraceptives and reproductive technologies often ignore hazards to women's health and other ethical and moral issues;

♦ Trafficking of women and girls is a major public health problem, little addressed by governments where the trafficking is most rampant;

♦ Sex-selective abortion is a misuse of technology that discriminates against the girl child;

♦ The rights of sexual minorities and sex workers, including access to health care, must be respected; The health and human rights of persons with mental disorders are currently ignored or inadequately addressed throughout the world. There is an urgent need to provide effective community based programs for persons with mental illnesses.

♦ The unjust social systems like caste in India and ethnic discrimination in other parts of the world have created a health apartheid and human rights reality for the socially marginalised;

♦ Indigenous people in developed and developing countries suffer health problems at a higher rate than the general population of the country in which they reside. As they are forced to follow the hegemonic cultural and development paradigms, they are being deprived of traditional knowledge and traditional systems of medicine and access to basic resources;

♦ The health and other human rights of persons with disabilities are currently ignored or inadequately addressed throughout the world;

♦ Migrant workers living and working in the developed and developing world suffer poorer health than the general population surrounding them.Their basic human rights are denied through lack of access to health, education, housing, etc,;

♦ Children living in difficult circumstances, such as street children. AIDS orphans, children of war, etc. face increasing discrimination. Corporate-led globalization only increases the poverty in which they live and robs them of a dignified future.

This Declaration:

Calls forAction by People's health Movement and Civil Society:

♦ Make concerted efforts to incorporate all the above marginalized populations, the "unheard and unseen", into their networks and facilitate their access to and influence in mainstream discourse.

♦ Ensure gender equity within the movement and within their own networks and communities.

Calls forAction by Governments

♦ Make concerted efforts to incorporate the needs of marginalized populations, the "unheard and unseen", in health and development strategies and social policies in a Right's context.

♦ Ensure availability of disaggregated data on health status and access to health services for different groups (age, sex, region, ethnicity etc.,) in the community to make discrimination to the right to health more transparent and enable actions to be taken.

In conclusion

We, the members of the People's Health Movement and the participants of the III International Health Forum for the Defense of People's Health commit ourselves to promoting the People's Charter for Health 2000 and the concerns and calls for action of the Mumbai Declaration 2004.

♦ **We believe that Another World is Possible;**
♦ **A Healthy World is Possible;**
♦ **Health for All Now! is Possible;**

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[1] Argentina, Australia, Bangladesh, Belgium, Brazil, Cambodia, Cameroon, Canada, Costa Rica, Cuba, Denmark, Ecuador, Egypt, France, Germany, Guatemala, Hong Kong, India, Iran, Italy, Kenya, Korea, Lebanon, Malaysia, Mauritius, Netherlands, Nicaragua, Nigeria, Norway, Pakistan, Palestine, Peru, Philippines, South Africa, Sri Lanka, Sweden, Switzerland, Tanzania, Thailand, USA, UK, Vietnam, Zambia, Zimbabwe.

AIDS: In Search of a Social Solution

Two decades after HIV/AIDS was discovered, it continues to spread across continents, infecting and killing millions and destroying entire communities. Sub-Saharan Africa, which accounts for 11 percent of the total world population, has 70 percent of all HIV/AIDS infections in the world, making it the worst-affected continent.

Although one may dispute the alarming figures, the fact remains that HIV/AIDS has had devastating consequences for countries, societies, families and individuals. It is a global crisis and the outlook is worsening, with India, China and Russia projected to be the next centres of the pandemic.

HIV/AIDS attacks every sector of the society, affecting food security, depressing national economies, and rolling back the development gains of the last thirty or more years, as the African experience has shown, especially in the worst-affected countries.

The fact that the disease strikes the most active and productive groups in a society, i.e. persons between the ages of 15-45 years, is a threat to human capital, the functioning of social institutions and social stability.

In Africa, young people and children not only bear the burden of the disease, many have lost parents and family members to HIV/AIDS. More than half of the HIV/AIDS sufferers are women, a reflection of their unequal and oppressed status in society wherein their sexual and reproductive health rights are denied.

Underlining the pandemic in which women figure disproportionately is the fact that HIV/AIDS thrives in and reinforces conditions of deprivation, poverty, oppression, conflicts, social violence, and social collapse. Thus HIV/AIDS has to be tackled from a social and economic perspective, taking into account the global structures and forces that have led to social and economic crises and exacerbated the vulnerability of populations to death and diseases including HIV/AIDS.

This concept of health, in which the root causes of ill health are not found in the diseases themselves but are embedded in the social and economic conditions prevailing in society, was recognised in the Alma Ata Declaration. In 1978, governments of the world had committed to achieving Health for All by the year 2000, and Primary Health Care (PHC) was identified as the key to achieving it. In the PHC vision, health cannot be separated from social justice if Health for All is to be achieved.

Hence, combating social inequalities within a country and between countries is fundamental to Health for All. This means challenging the power structures and policies that engender ill health, be they governments, the World Bank-IMF, unequal trade agreements, structural adjustment policies, corporate-driven privatisation or free-market fundamentalism, all of which have severely affected public health systems particularly in the Third World.

It is within this context that the HIV/AIDS catastrophe has to be considered. HIV/AIDS cannot be tackled with technocentric and medical solutions alone. HIV/AIDS requires an integrated social, economic and political response, where health is recognised as a fundamental human right and health inequities are simply unacceptable.

This document is a joint effort of the Third World Network and the People's Health Movement. We hope that the articles and perspectives in this book can be a useful source for campaign and advocacy.

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